

Training Curriculum on Drug Addiction Counseling



Chapter 5

Key Drug Addiction Counseling Skills
and Techniques (Role-play sessions)



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TRAINING CURRICULUM ON DRUG ADDICTION COUNSELING

TRAINER MANUAL



TABLE OF CONTENTS

Part I: The Basics of Individual Drug Addiction Counseling

Chapter 1. Trainer Orientation

Chapter 2. What is Drug Addiction Counseling?

- 2.1. Introduction to general counseling
- 2.2. Basic concepts of drug addiction counseling
- 2.3. Key principles in drug addiction counseling
- 2.4. Counseling skills
- 2.5. Counseling techniques
- 2.6. Counseling procedures

Chapter 3. Drugs, Drug Addiction, and Treatment Approaches

- 3.1. Drugs, drug use and its consequences
- 3.2. Alcohol problems
- 3.3. The basic of addiction
- 3.4. Basic treatment principles
- 3.5. Important factors for successful treatment
- 3.6. Treatment for heroin addiction

Chapter 4. Motivational Interviewing

- 4.1. The Stages of Change Model and key concepts in motivational interviewing
- 4.2. Principles and steps for motivational interviewing
- 4.3. Linking motivational interviewing to stages of change strategies

Chapter 5. Key Drug Addiction Counseling Skills and Techniques (Role-play sessions)

- 5.1. Client assessment
- 5.2. Problem solving
- 5.3. Goal setting
- 5.4. Reducing risk

Chapter 6. Relapse Prevention

- 6.1. Relapse prevention therapy
- 6.2. Refusal skills
- 6.3. Coping with cravings
- 6.4. Stress management
- 6.5. Time management

TABLE OF CONTENTS (cont.)

Part II: Advanced Individual Drug Counseling

Chapter 7. Managing Intoxication and Hostility

- 7.1. Anger management
- 7.2. Dealing with aggressive and potentially violent behavior
- 7.3. Conflict resolution
- 7.4. Managing intoxicated clients

Chapter 8. Special Populations

- 8.1. Working with families
- 8.2. Working with youth
- 8.3. Working with women

Chapter 9. Clinical Supervision and Support

- 9.1. Framework for clinical supervision
- 9.2. The basics of clinical supervision
- 9.3. Case conferencing
- 9.4. Preventing and managing burnout

Part III: Appendices

Appendix I: Sample training schedule

Appendix II: Sample evaluation form

Appendix III: Sample written exam

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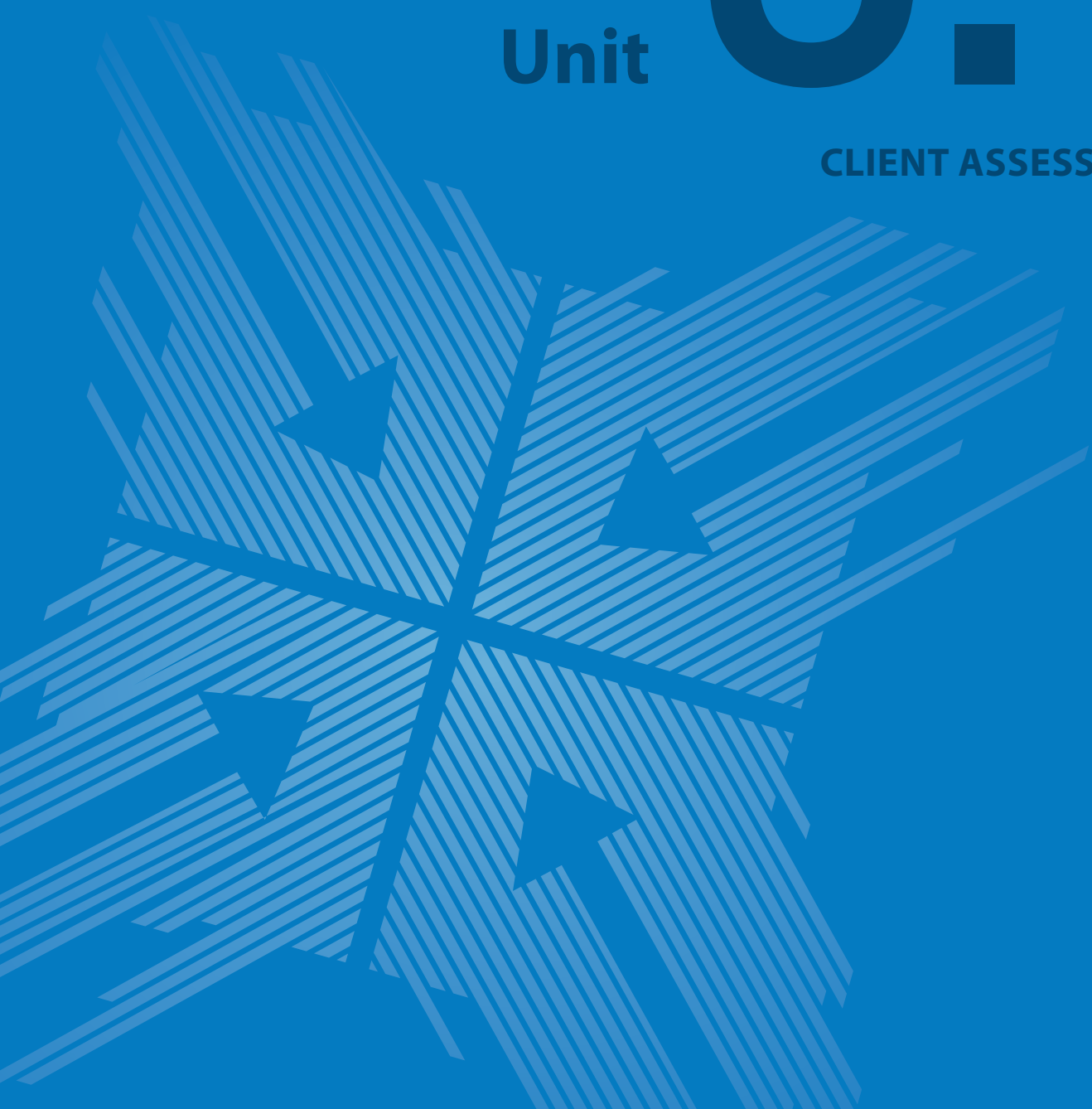
CHAPTER 5

KEY DRUG ADDICTION COUNSELING SKILLS AND TECHNIQUES

Unit 5.1: Client Assessment	3
Unit 5.2: Problem Solving	39
Unit 5.3: Goal Setting	61
Unit 5.4: Reducing Risk	81

Unit 5.1

CLIENT ASSESSMENT



OVERVIEW

Introduction

5 Min

Introduce the unit by explaining that you will discuss the basics of initial client assessment, client assessment procedures, and their application in counseling.

Presentation

75 Min

Use the PowerPoint slides to present on client assessment.

Conclusion

10 Min

Review the key points of this unit and answer the participants' questions (if any).

Unit 5.1: Client Assessment

Goal: To help participants understand the basic concepts of client assessment, client assessment procedures, and the steps in conducting an assessment.

Time: 90 minutes

Objective: At the end of this unit, participants will be able to:

- understand why it is important to assess clients at the intake stage
- understand the procedures and concepts needed to assess clients
- demonstrate their client assessment knowledge and skills through role-playing
- apply their client assessment knowledge and skills while counseling drug users

Methodology:

- Presentation and discussions
- Small-group exercises
- Role-play

Teaching aids:

- PowerPoint slides
- LCD projector
- Handout# 5.1-1: Role-play (Trainer instructions)
- Handout# 5.1-2: Sample Assessment Screening Form
- Handout# 5.1-3: Individual Service Plan

Slide 1



👤 Say: *Assessing a client at intake is a delicate step in treatment and rehabilitation because clients are often depressed, anxious, suspicious or confused. Even those who appear to be calm and positive are often hiding their feelings; they will need a lot of encouragement and support to talk about their intimate personal problems. During the first intake interview, explain that their sessions are confidential. The initial guided assessment (with a specific set of questions) is an important tool for you to gather a complete history from each of your clients. However, your client may be scared of completing a questionnaire. Therefore, it is better to start the interview informally, rather than putting the questionnaire between you and the client. After breaking the ice by showing that you care about your client's feelings, you can start filling in the assessment forms.*

Teaching instructions: You may wish to discuss the additional introductory points below with your participants, time-permitting.

FYI: While some clients may arrive with the expectation that you can help them, others will simply resist and test your understanding of drug use. Some may see you as a negative figure, part of a system that has never helped them before. Your job as a counselor is to approach all new clients with compassion, no matter how hostile or difficult they may be. Drug users who have been forced to join treatment by a spouse, parents, a doctor or a legal institution, may resist by refusing to answer any of your questions. You can respond to this attitude with empathy by saying, for example: "I can understand your feelings about coming here today, but problems can be solved and we will try to do it together. But first, I would really like to learn more about you."

Slide 1 (cont.)

You may not be able to complete a full assessment during the first meeting. The various parts of the client's file can be filled in during successive counseling sessions, after you have established feelings of trust and confidence between you and the client. The file allows for continuous record keeping, even during the rehabilitation phase. Use additional information sheets to record major events (lapses and relapses, as well as important achievements) for as long as you stay in touch with the client.

Slide 2

LEARNING OBJECTIVES

By the end of this unit, participants will:

- understand why assessments are important
- understand the procedures and contents of an assessment
- demonstrate their knowledge and skills of client assessment through role-play
- apply their client assessment knowledge and skill while counseling drug users

Teaching instructions: Use the bullets on this slide to present directly.

Slide 3

WHAT IS ASSESSMENT?

- The first of a number of ongoing steps in treatment and recovery
- The process of learning the personal history of the client by listening to the client and his/her family
- Crucial for the counselor to determine the specific interventions that will help to set the client's recovery goals

👤 Say: *Assessment is the first of a number of ongoing steps in treatment and recovery. It is the process we use in the first few meetings with the client ('intake') to identify and evaluate the client's general situation, including his/her strengths, weaknesses, problems and needs, in order to develop the client's treatment plan and recovery goals.*

Assessment is the process of learning the personal history of the client by listening to the client and his/her family. We cannot succeed in helping until we have knowledge of a client's background, including personal, educational and work history, in relation to his/her drug use.

Assessment helps counselors determine what specific interventions will help to establish clients' recovery goals, and to make the necessary lifestyle changes to reach those goals.

Your challenge in the assessment stage is to learn about your client's life and help him/her to recognize the value of counseling. There may be many pressures in your client's life that have led to his/her drug use. You need to learn as much as you can about this background before you can presume to judge. It is not helpful to make your clients feel guilty.

Slide 4

ASSESSMENT OBJECTIVES

- Establish a therapeutic relationship
- Clarify the nature and severity of the client's problems
- Formulate those problems into a treatment plan

👤 Say: *There are three main goals that you should try to achieve in an assessment:*

- *First, you should try to develop your relationship with your clients so that they will feel confident about your ability to help and assist them with their problems.*
- *Then, you should try to clarify the nature and severity of the problems that they have.*
- *After identifying existing problems, you should help them to identify a plan of action to respond to those problems, and you can coach them on how to follow that plan.*

To do this, you need to achieve the following:

- *Gather information about the client's social, physical, mental and work history*
- *Motivate the client to engage in treatment, if necessary*
- *Learn about the factors that led the client to use drugs*
- *Identify the client's emotional, personal and economic needs that may require immediate attention and care*
- *Make the necessary arrangements to address those needs*
- *Identify the client's strengths (i.e. what is the potentially supportive and useful elements of his/her life)*
- *Provide information to the client about how you will work with him/her, the center/ service treatment philosophy and program structure*

Slide 5

CORE ASSESSMENT ISSUES

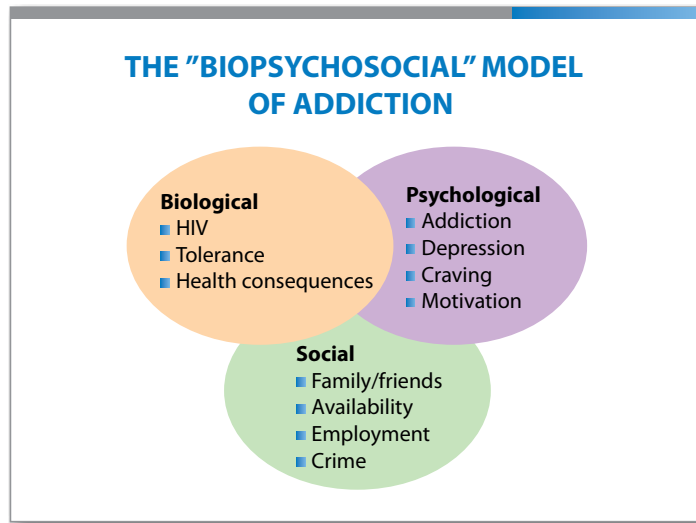
- What does the client want?
- Is the client addicted?
- What is his/her level of tolerance?
- Is the client using or addicted to other drugs?
- What is his/her motivation for change?
- What are some of his/her social supports?
- Does the client have any other medical or psychiatric conditions?

👤 Say: *You want to understand what the clients actually want. Why have they come to see you?*

You're trying to understand whether or not they are addicted to drugs, because the various solutions you choose will depend on their addiction status. For heroin users, you really want to know how much and how often they use heroin each day. You want to know how tolerant they are to the effects of heroin and you want to know if they are using any other drugs.

You need to make some assessment of how motivated they are to do something about their drug use. Just because somebody comes to see you does not mean that he/she wants to change his/her behavior. You also need to know about the social support network that can help them, because the more social support they have, the more likely they are to be successful in changing their behavior. You also need to know if they have any health, social or psychiatric problems, because those may interfere with their capacity to change their lifestyle.

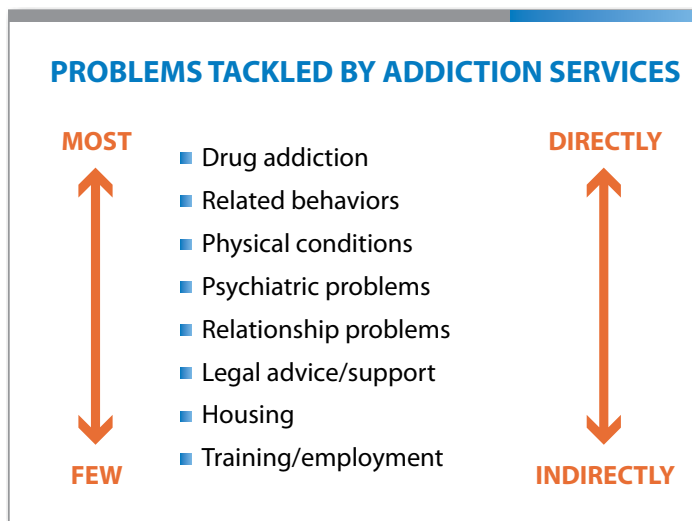
Slide 6



👤 Say: *Many people think of drug addiction as a moral weakness. In fact, addiction is a chronic, relapsing medical condition that has biological, sociological and psychological consequences. As a counselor, you need to focus on all three components.*

If you just treat one component, the problem will continue to exist. In your future role as a counselor, you will find that clients will bring a variety of problems to you. You will directly manage some of these problems without referral. However, sometimes you will recognize serious problems that are outside of your expertise. You might need to refer them to other agencies or people to help provide this service. Even though you do not deal with that problem directly, it is still important that you do what you can to assist your client, and that you recognize that this is something about which your client is concerned.

Slide 7



Say: *To engage clients fully, remember that if you deal with the problem that they are most concerned about, you are more likely to gain their trust to deal with the problems that you are most concerned about.*

Many clients will have problems with their family, employment, the law, and/or housing, and you might need assistance from others to help with these problems.

This slide shows that most drug counseling services deal directly with problems such as drug use and related behaviors, but few deal directly with problems such as employment and housing. You are likely to refer your client for assistance with these problems. This does not mean that those problems are less important. What it means is that drug counseling specializes in the field of drug treatment, recognizing that these other problems can significantly interfere with successful rehabilitation. The assessment will give you insight about whether these problems exist, and how best to respond.

Slide 8

TO MAXIMIZE TREATMENT ADHERENCE

Prioritise psychosocial issues first


- Emotional stability
- "Chaotic" drug use
- Accommodation
- Income

👤 Say: *To maximize treatment outcomes, counselors need to give high priority to psychological and social issues, in addition to clients' drug use issues. Clients with serious psychological or social problems will have serious difficulty in succeeding in drug counseling, treatment and rehabilitation.*

Slide 9

FIVE CRITICAL COMPONENTS OF AN INITIAL ASSESSMENT

- Psychosocial
- Drug use
- Medical and psychiatric issues
- Treatment selection issues
- Examination

 **Say:** *These are the five critical components that must be addressed in your initial assessment. We will spend some time talking in detail about each.*

Slide 10

PSYCHOSOCIAL ISSUES

- Demographics
- Relationship with family
- Relationship with partner
- Education and employment
- Criminal justice
- Living circumstances
- Sources of income

👤 Say: *Apart from basic demographic information such as the client's name, address, age, and gender, you will also need to know who the client is living with, their roles and attitudes toward the client, and whether any member of the family also has a history of drug use. Ask about close friends, relatives and other significant people who may influence your client. You need to assess the degree to which your client's family and other relationships have been affected by his/her drug use.*

Maintaining a compassionate approach, you can explore the following areas:

- Do you have a job? Tell me how you make a living.
- Do you have any debts? Please tell me about them.
- Have you ever had to sell your valuables, or those belonging to other members of your family, to purchase drugs?
- Have you ever had any trouble with the police? Tell me what happened.

Ask your clients whether they currently have any problems with the police, or if they have been in trouble with the police before. Are they involved in any criminal activities such as stealing, drug dealing or prostitution?'

Where do they live? What do they do to get money?

Slide 10 (cont.)

Confronted by their own replies, it becomes quite difficult for clients to continue to deny that their drug use has serious consequences. It also becomes difficult for them to look for scapegoats to hold responsible for these problems, because all of these consequences are client-centered.

Teaching instructions: Facilitate a large-group discussion about the kinds of information to look for when making an assessment of the client's drug use history.

Slide 11

DRUG USE HISTORY

- Primary drug
 - Average daily use (quantity/frequency/duration)
 - Time last used
 - Route of administration
 - Age commenced
 - Periods of abstinence
 - Severity of addiction
 - Previous treatment(s)
- Other drugs
 - Current and previous
 - Addiction

👤 Say: *Some drug users may come to your counseling services for reasons other than wanting to lead a drug-free life. They may come to seek relief from withdrawal symptoms. You will need information about your clients' past and present drug use to gauge their situation.*

It is important to ask your clients the following:

- *How and under what circumstances did you begin to use drugs and what types of drugs have you used?*
- *How long have you been using each of them?*
- *How much have you used in the past, recently, and currently. What is the frequency and duration of use?*
- *Which drug do you perceive caused your main problem(s)?*
- *How do you take this drug? Are you swallowing, smoking or injecting?*
- *If you inject, do you do it alone or in the company of friends who share needles?*
- *Are you cleaning the needles before and after each use? (Hepatitis and HIV infection are real threats to drug users who share needles. The client may not be aware of the health risk at first, but in the process of counseling and rehabilitation, he/she may renew the desire to care for his/her health.)*

Your client may have participated in other treatment programs in the past. You should ask about previous treatment programs your client has tried and how he/she perceived the success of these approaches. It may be helpful to learn about the frequency and duration of his/her abstinence episodes for each drug. Ask your clients how long the previous periods of abstinence lasted, and how long it took to relapse. People relapse for different reasons. Generally speaking, each client has his/her own weak points or "personal triggers" that can lead to relapse. This information will be very important during the rehabilitation and relapse prevention phase.

Slide 12

MEDICAL AND PSYCHIATRIC ISSUES

- Blood-borne viruses (HIV and Hepatitis)
- Pregnancy
- Other major medical conditions
 - Liver
 - Heart
- Major psychiatric conditions
 - Depression, suicide, psychosis
- Opioid-related overdose

Say: *We also need to discuss medical and psychiatric issues, as they can be closely related to the client's drug use. As counselors, we need to know which medical or psychiatric services the client should be referred to in order to ensure timely, effective and comprehensive treatment.*

- *Has the client been tested for HIV? It is essential to counsel the client before and after HIV testing.*
- *If the client is female, is she pregnant?*
- *Does the client have any problems with his/her heart or liver?*
- *Has the client ever attempted suicide? How would you ask this question? This is a sensitive issue and should be raised cautiously. You could ask the client if he/she had ever thought life was so difficult that he/she thought it wasn't worth going on. If the client says yes, then ask what did he/she do. You can then explore whether he/she still has those thoughts now. If the client does, he/she will require a medical assessment.*
- *Has the client ever had an overdose?*

Slide 13

SELECTION OF TREATMENT

Assess the following:

- Trigger for seeking treatment
- Client goals for treatment
- Stage of change
- Commitment to treatment
 - Confidence to undertake the task (scale)
 - Willingness to change the situation (scale)

👤 Say: *It is important for you to know what triggered your client to join a treatment program. Is it because his/her spouse left? Has he/she been arrested by the police recently? Is the client scared about the possibility of losing his/her job? Is the client being driven out of home by his/her parents? Has a close friend died of an overdose? These are some of the reasons that drug users commonly give when they join a treatment program.*

Many young drug users, particularly those who have been forced into treatment, tend to deny or dismiss the harm caused by their drug use. The client may claim that everything is all right.

- *How motivated is the client to recover from his/her drug use and related difficulties?*
- *What are the client's expectations from your services?*

It's now the right time to ask your clients about their priorities. Some drug users may say they want their spouse to return home. Others may tell you they are stressed because of their debts, or because they have been suspended from work. Their priority is to pay back their debts or to get their jobs back.

Get a sense of your client's commitment and capability for treatment by asking about his/her willingness to change and his/her confidence to change. The sum of these issues will determine the most appropriate intervention.

Slide 14

EXAMINATION

- Mental state
 - Mood
 - Cognition
 - Behavior
- Injection sites
- Signs of intoxication/withdrawal
- Nutritional state

👤 Say: *When you first meet your client, you should conduct a basic assessment of his/her mental state to see whether your client's drug use has affected his/her mood, behavior and cognition. Organize your observations around the following areas:*

- General appearance and behavior
- Speech
- Affect and mood
 - *Appropriateness*
- *Thought (stream, form, content)*
- *Perception*
- *Cognition*
- *Judgment*
- *Insight*
- *Rapport*

You may wish to look at your client's injection sites to determine whether there is any serious damage. You should also look for signs of intoxication or withdrawal, to see whether your client's account of his/her recent drug use is consistent with your observations. You should also consider his/her overall nutritional state.

Slide 15

ADDICTION (1)

1. Tolerance:

- Would you say you had to use more [substance] to get intoxicated or the desired effect?

OR

- At any time, did you find that you seemed to be getting less of an effect when you used your usual amount?

2. Withdrawal:

- Did you experience withdrawal when the effects of [substance] began to wear off?

OR

- Did you take more [substance], or take a similar drug to relieve or avoid feeling withdrawal symptoms?

- 3. **Time:** Would you say you spend a large amount of time obtaining [substance], using it, or recovering from its effects?

- 4. **Quantity:** Would you say you used [substance] in larger amounts or for a longer period of time than you would have wished?

Did you want to cut down or stop using [substance] or have you had problems trying?

Teaching instructions: Note that the questions continue onto the next slide.

👤 Say: *To gauge whether or not your client is addicted to the main drug he/she uses, you can ask the following questions. If your client provides a “yes” to 3 of the questions or more, then he/she is addicted to that drug.*

You might start with: “Here are some questions about the problems you may have experienced with your use of [main drug]. Thinking over the last 12 months...”

Slide 16

ADDICTION (2)

- 5. Did you reduce or give up important work, recreational or social activities as a result of your [drug] use?
- 6. Did you continue to use [drug] even though you knew it was causing or making a physical or a psychological problem worse?

Slide 17


PHYSICAL ADDICTION

- **Tolerance**

Higher dose of the drug is needed to achieve the same effect

- **Withdrawal syndrome**

Develops when drug taking ceases abruptly

 **Say:** *There are two criteria you can use to assess your client's level of physical addiction: **tolerance** and **withdrawal syndrome**.*

Slide 18

OPIOID WITHDRAWAL

Symptoms

- Anorexia and nausea
- Abdominal pain or cramps
- Hot and cold flushes
- Joint and muscle pain or twitching
- Poor sleep
- Drug cravings
- Restlessness/anxiety

Say: *Opioid users may experience moderate to severe but not life-threatening withdrawal syndrome. Signs and symptoms of opioid withdrawal may be mistaken for a bad dose of the 'flu'. Heroin withdrawal is rarely fatal, unless the person becomes dehydrated or has a serious, co-existing medical condition.*

The onset and duration of withdrawal varies according to the half-life of the drug used. Withdrawal symptoms from heroin may commence 6-12 hours after the last dose, and may last for 5-7 days. With methadone, withdrawal may not commence for 2-3 days after the most recent dose and last for up to 3 weeks.

Slide 19

OPIOID WITHDRAWAL

Signs

- Yawning
- Tears
- Dilated pupils
- Sweating
- Runny nose, sneezing
- Tremors
- Goose bumps
- Diarrhea and vomiting

👤 Say: *The onset and duration of withdrawal varies according to the drug used. Withdrawal symptoms from heroin may commence 6-12 hours after the last dose, and may last for 5-7 days. Methadone withdrawal may commence 2-3 days after the last dose and last for up to 3 weeks. Signs include large pupils. Pupils will constrict when individuals are intoxicated. Tears, sweating, running nose and goose bumps are also signs.*

Slide 20



Teaching instructions: Show this photo and ask the participants whether they think this woman is currently experiencing withdrawal or intoxication. Why?

Say: *The answer is that her dilated pupils indicate that she is experiencing withdrawal from heroin. However, she could also be intoxicated from ecstasy or methamphetamines.*

Slide 21

1. Did you ever think your [drug] use was out of control?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
2. Did the prospect of not taking any [drug] make you anxious or worried?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
3. Did you worry about your [drug] use?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
4. Did you wish you could stop using [drug]?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
5. How difficult would you find it to stop or go without [drug]?	0 Easy	1 Quite difficult	2 Very difficult	3 Impossible

Teaching Instructions: Use the Severity of Addiction Scale cutoff scores to explain to participants how to rank clients' severity of addiction for various drugs.

FYI: SEVERITY OF ADDICTION SCALE: Cut-off scores

- Methamphetamine: 4 or more (Topp & Mattick, 1997) (Topp, 2009)
- Alcohol: 3 or more (Lawrinson, Copeland et al., 2007)
- Cannabis: 3 or more (Swift, Copeland & Hall, 2002) new paper gives score of 4 or more for adolescents (Copeland, April 2009)
- Heroin: 3 or more (González-Sáiz et al., 2009)
- Cocaine: 4 or more (González-Sáiz et al., 2009)


👤 Say: *Apart from the sample Assessment Screening Tool (Handout #5.1-2) this is another tool you can use. This tool is very useful for assessing the severity of your client's psychological addiction. You can also use it to talk to your client about his/her own perception of the severity of his/her drug use.*

The Severity of Addiction Scale (SAS) is a five-item questionnaire designed to measure the degree of a client's psychological addiction to drugs. The SAS focuses on the psychological aspects of addiction, including impaired control of drug use, and preoccupation with and anxiety about drug use in the past 12 months. The SAS appears to be a reliable measure of addiction. It has demonstrated good psychometric properties with heroin, cocaine, amphetamine and cannabis users. Cut-off scores of 4, 3 and 6 are indicative of amphetamine, cannabis and benzodiazepine addiction, respectively.

Slide 22

SUCCESSFUL ASSESSMENT

1. Recognize and admit that they have a problem with drug use
2. Agree to accept counseling and treatment voluntarily
3. Understand the pros and cons of drug use
4. Understand they will have to work very hard and cooperate with you if they really want to solve their problems

 **Say:** *It is important for you to help your clients talk through these issues so that they will be able to start taking responsibility for their drug use.*

The first meeting will be successful if you can help your client to:

1. *recognize and admit that he/she has a problem with drug use*
2. *agree to accept counseling and treatment voluntarily*
3. *understand that while drugs may appear to help him/her to feel better and cope with problems, drug use can be a negative, destructive force in his/her life*
4. *understand that he/she will have to work very hard and cooperate with you if he/she really wants to solve his/her problems. You may need to assure your client that through counseling, he/she can learn healthier, safer ways to address many of his/her problems*

During the assessment, your job is to hold a mirror up to your client by helping him/her to tell you his/her life story. Then, as you talk about this history with your client, you can help him/her to accept the challenge of counseling and treatment. Your client needs to know that it will be hard work, but it will be worth the struggle, and you will be there to help.

Teaching instructions: Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.

Handout 5.1-1 (This sheet for trainers only)


Sample Role-play

Teaching instructions: Arrange the class into groups of 3.


Allow groups of three to assign themselves to the following roles: client, counselor, or observer. Each of these roles provides a different perspective on the counseling experience. The observer's job is to look at the quality of the counseling session, and to see whether or not the counselor misses things or opportunities. The observer is also there to observe the characteristics of the client.

The counselor should use the skills that were discussed in this and previous units to get the information he/she needs to make an assessment.


Call all of the "clients" aside

 **Say:** *I don't want you to make it too easy for the counselors. You should try to make them work hard to get the information from you. I'd like you to give answers that are either a little unclear or are not good answers to their questions. When the counselors persist, you can then give them the information they are asking for.*

Teaching instructions: Return to the entire group of participants.

 **Say:** *Now I want you to get into your groups of 3 as discussed, and spread out around the room. You will have 20 minutes for the role-play.*

Teaching instructions: Outline the role-play. Give the "counselors" the Sample Assessment Screening Form (following page) with additional questions for specific concerns such as mental health and family functioning.

 **Say:** *It is important to note that an initial assessment screening session should be short, but meaningful. The client should not feel as if the experience has been too intrusive or overwhelming. Only collect enough data to make the necessary decisions; you can make a fuller assessment later. You will need to decide first whether the client requires urgent medical attention. Your other primary concerns are the client's history of drug use, problems associated with drug use, and his/her physical and mental health.*

Questionnaires are only a part of an assessment; engagement, building rapport, observation, elaboration on answers, and exploring significant statements and answers are all part of the assessment process. Never just fill out a questionnaire and assume that an assessment has been undertaken.

Handout 5.1-2

SAMPLE OF ASSESSMENT SCREENING FORM

Social Record

Client ID:.....

PART 1: SOCIO-DEMOGRAPHIC AND MEDICAL INFORMATION

I. General Information

1. Name: First name initial Last name initial

2. DoB (dd/mm/yyyy) / / 3. Age: 4. Gender: Male Female:

5. Education:

- None
- Primary school
- Secondary school
- High school
- University/tertiary

6. Marital status:

- Never married
- Married
- Separated
- Divorced
- Widow

7. Contact address:

House:
Ward:
Dist:
City/province:

8. Client is a peer educator

- Yes
- No

9. Does spouse/family use drugs?

- Yes
- No

10. Date of entering O6 rehabilitation center (if any):

..... / /

* Fill: 99/99/9999 if not entering O6 center

11. Release date: / /

99/99/9999 if not from O6 center

II. Employment and Income Information

12. Employment

- Unemployed, looking for a job
- Unemployed, not looking for a job
- Part-time employee
- Working for family
- Full-time employee

Type of work:

13. Does the client want to change his/her employment situation?

- Yes
- No

If yes, describe:

Handout 5.1-2 (cont.)

IV. Transportation

17. Do you have transport?

- Bike Bus
 Motobike None
 Car

18. Does the client need other transportation arrangements?

- Yes
 No

* Client ID is the combination of first name initial, last name initial, date of birth (dd/mm/yy), gender (1 male, 2 female), and district (1: Ba Dinh; 2: Dong Da; 3: Hoan Kiem; 4: Hoang Mai; 5: other districts)".

V. Family & social support

19. Evaluate the level of support that the client receives

	Psychological emotional support	Financial support	Health care support	Other
1. Spouse				
2. Partner				
3. Parent(s)				
4. Child				
5. Sibling				
6. Other relatives				
7. Friends				
8. IDU Peer Educators				
9. Other				

Code: 1. Significant support 2. Occasional support 3. Weak support 4. Support not available or unknown

20. Client's level of satisfaction with current level of social support:

- Not at all Slightly Moderately Considerably Extremely

21. Social support assessment

- Client appears to be isolated and lacking any significant, reliable source of social support. Client feels the need for support (immediate intervention is needed)
 Client appears to be lacking in significant sources of social support, but seems comfortable with the situation (intervention may be explored at a later time)
 Client has support, but feels the need for more support (explore more)
 Client has an active, acceptable social support network (no need for intervention)

Handout 5.1-2 (cont.)

VI. Health information

22. Has the client been tested for HIV?

- No
- Yes, negative
- Yes, positive
- Yes, unidentified
- Yes, did not come for the result

Date of testing:/...../.....
Place of testing

23(a). Has the client been tested for HBV?

- No
- Yes, negative
- Yes, positive
- Yes, unidentified
- Yes, did not come for the result

Date of testing:/...../.....
Place of testing

23(b). Has the client been tested for HCV?

- No
- Yes, negative

Date of testing:/...../.....
Place of testing

- Yes, positive
- Yes, unidentified
- Yes, did not come for the result

24. Current health status?

- Excellent
- Good
- Fair
- Poor

25. Has been treated any of the following chronic diseases?

- Hepatitis B
- Hepatitis C
- Tuberculosis
- Others (specify):

26. Has any STIs? (specify)

27(a). Client is on ARV treatment

- Yes
- No

27(b). Level of treatment adherence?

- Excellent
- Good
- Fair
- Poor
- Not at all

28(a). Have you ever practiced unsafe sex with women in the last 12 months?

- Yes
- No

28(b). Have you ever had unsafe sex with men in the last 12 months?

- Yes
- No

29. Have you ever had unsafe injecting behavior in the last 12 months?

- Yes
- No

Handout 5.1-2 (cont.)

VII. Mental health information

Attention: If the client answers "no" to any of the following questions, or his/her family reports memory loss, refer the client to the clinic's doctor.

30. Does client know where he/she is?

- Yes
- No

31. Does client know why he/she is here?

- Yes
- No

32. Are any of the following a problem to the client?

- | | |
|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Delusion |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Withdrawal/Social Isolation |
| <input type="checkbox"/> Forgetfulness | |

33. Mental health assessment

- Client is in immediate need of evaluation by doctor.
- Client is in need of intervention, but the situation is not critical.
- Client may need intervention at a later date, but is presently functioning well.
- Client is coping well. There is no need for intervention at this time.

Handout 5.1-2 (cont.)

Client ID:.....

PART II: DRUG USE INFORMATION

Date of first visit to RCS center (dd/mm/yyyy): / /

VIII. Drug use history: (Before entering the RCS Center)

34. Substance use:

Kind of drug	Age commenced	Average daily use (times/day)	Total of money spent on drugs each day	Route of administration *	Time last used (dd/mm/yy)	Most commonly used **
1. Opiates/heroin						
2. Cocaine/crack						
3. ATS						
4. Cannabis						
5. Alcohol						
6. Tobacco						
7. Other (specify)						

* : 1- oral; 2- nasal; 3- smoking; 4- non-IV injection; 5- IV injection; 6- never used

** : 1- primary; 2- secondary; 3- tertiary

35. How many times has the client undergone drug treatment: time(s)

36. How many times has the client relapsed: time(s)

37. How long has the client abstained from the drug, each time?

Number of abstinence					
Duration (number of days)	1st	2nd	3rd	4th	5th

38. Have you ever shared needles and syringes?

Yes

No

Unknown

Handout 5.1-2 (cont.)

39. Have you ever had an overdose?

Yes

No

How many times?

40. Have you ever been involved in criminal activities? Yes No If yes, tick all that apply

Drug dealing

Selling sex

Stealing

Violence

Other, specify

Handout 5.1-3

INDIVIDUAL SERVICE PLAN

Client ID:.....

RECOVERY PLAN

Name:

Date:/...../.....

1	Identified problems/needs
2	Action steps to address problem/needs
3	Social support, timeline, and follow-up plan
4	Referral provided

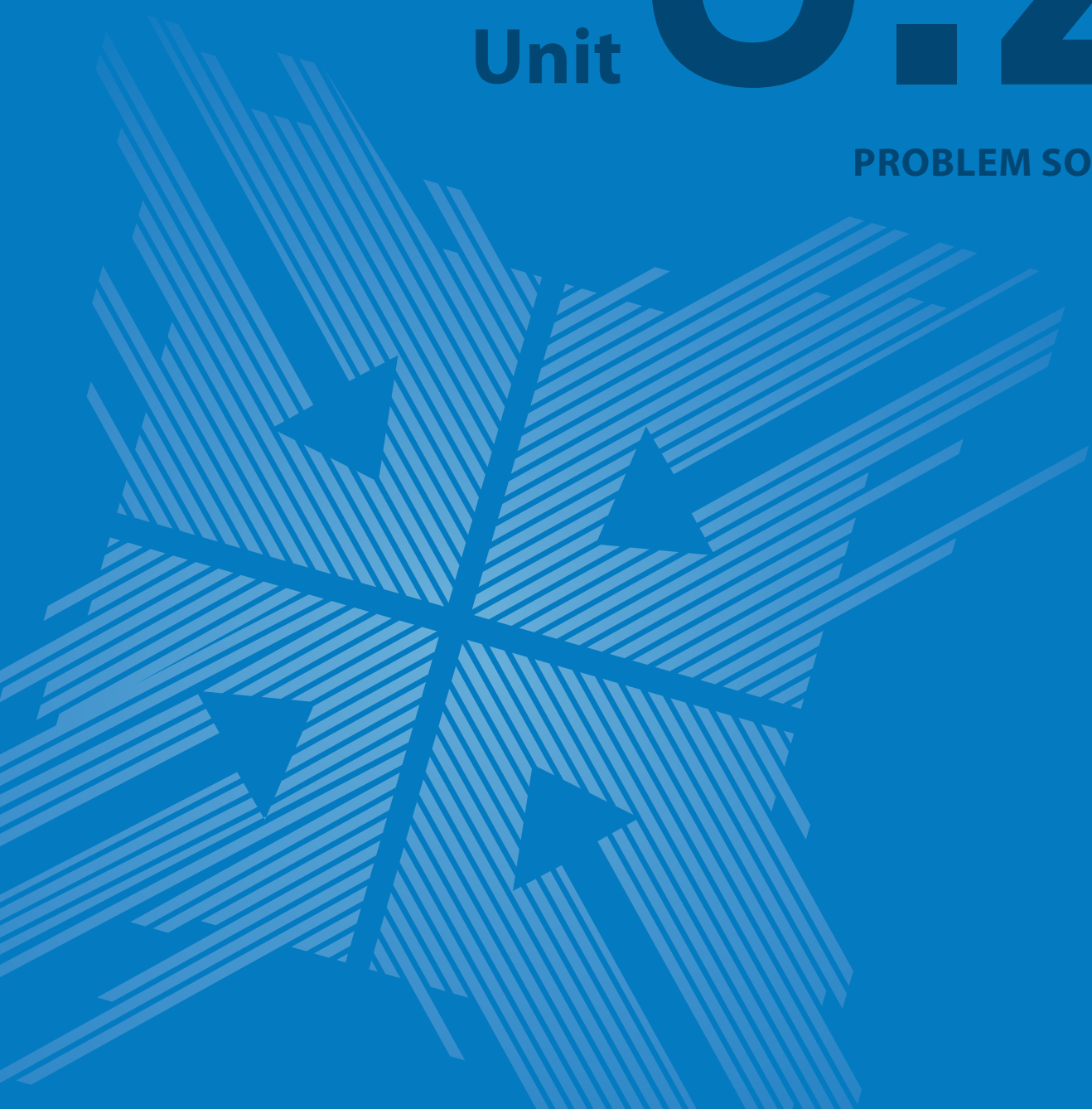
Is the client at high risk of relapse? Yes No

Sources:

John Howard, 2006. A Toolkit for Building Capacity For Community-based Treatment and Continuing Care of Young Drug Abusers in The Greater Mekong Subregion. The United Nations Economic and Social Commission for Asia and the Pacific.

Unit 5.2

PROBLEM SOLVING



OVERVIEW

Introduction

2 min

Introduce the unit by explaining that you will discuss problem solving, the steps involved, and their application in counseling.

Presentation

45 min

Use the PowerPoint slides to present on problem solving and its application in counseling.

Conclusion

8 min

Review the key points of this unit and answer participants' questions (if any).

Unit 5.2: Problem Solving

Goal: To help participants understand problem solving, its rationale, and the steps involved in counseling.

Time: 55 minutes

Objective: At the end of this unit, participants will:

- understand the rationale behind problem solving
- understand the steps in the problem solving process
- be able to demonstrate their problem-solving knowledge and skills through role-playing
- know how to apply problem-solving skills when counseling drug users

Methodology:


- Presentation and discussion
- Small-group exercises
- Role-play

Teaching aids:

- PowerPoint slides
- LCD projector
- Handout #5.2-1: Problem-solving worksheet

Slide 1



 **Say:** *We all face problems.*

We occasionally face problems that seem overwhelming, and we may try to cope with them by avoiding them or by worrying excessively about them. These strategies are generally not very helpful: doing little to resolve a problem will often make it worse.

Structured problem solving is a technique that can help you find solutions to the problems you face. With just a little bit of practice, you'll find that the method is easy to use and can help you with any problem.

Slide 2

LEARNING OBJECTIVES

At the end of this unit, participants will:

- understand the rationale behind problem solving
- understand the steps in the problem-solving process
- be able to demonstrate their problem-solving knowledge and skills through role-playing
- know how to apply problem-solving skills when counseling drug users

Teaching instructions: Use the bullets on the slide to present directly.

Slide 3

ACTIVITY

- How do YOU solve your everyday problems?
- What steps do YOU go through?

Teaching instructions: Divide the participants into 2 groups and ask them to discuss how they solve everyday problems. What steps do they go through? Tell them they will have 5 minutes for discussion, then 1 person will report for each group. Allow 2 minutes for report-outs from each group.

Slide 4

BACKGROUND

- The ability to solve problems is one characteristic of healthy living
- Many drug users appear to have poor problem-solving techniques
- Problem-solving capacity affects relapse risk
- Problem-solving training is associated with better treatment outcomes
- Problem solving can be done individually or in groups

👤 Say: *Drug users need to find solutions to many problems if they are to reduce their drug use and/or abstain, and make substantial lifestyle changes. Some clients may have so many problems that even their minor problems seem overwhelming. For example, a straightforward goal such as going to an employment center to meet a counselor and sign up for assistance requires them to solve a number of problems. The client may not have readily available transportation, he/she may need childcare, or the only available appointments may conflict with other important activities.*

For many clients, their heroin use has led them to avoid such problems or to make impulsive decisions that are not in their best interest. This poor problem-solving behavior can have negative consequences that increase the severity of existing problems, or create additional problems.

The goal of this training is to teach clients to identify, analyze and find solutions to the many problems they will face in their efforts to stop their drug use and make lifestyle changes.

Counselors should provide a rationale for this component.

Slide 4 (cont.)

FYI: People trying to recover from heroin use often find themselves confronted by difficult situations. These situations become problematic if they do not have an effective response to them. Heroin users are likely to encounter several types of problems:

- Finding themselves in places/situations where they have used heroin and other drugs
- Having to deal with social pressure
- Suffering drug cravings
- Relapsing

People making positive lifestyle changes often encounter these common problems:

- Having difficulty finding the time to participate in social activities or hobbies
- Lack of transportation
- Problems with childcare
- Job-related issues
- Family pressure
- Legal problems

To solve a problem effectively, you need to recognize that you have a problem, think it through, and resist the temptation to respond to your first impulse or do nothing. If you don't find good solutions, your problems can build up over time, and the pressure may eventually trigger drug use. Counselors can explain to their clients that they have a program to help them become better problem solvers. It will take some time and practice to become good at this technique.

Slide 5

TIMING

Problem solving works best when the client:

- is not impaired (e.g. experiencing withdrawal, substantial cognitive impairment or intoxication)
- is in the action stage
- needs a variety of techniques to assist comprehension and remembering

NOTE: Break the action plan into individual steps

Teaching instructions: Show only the title of Slide 5. Ask the participants when they think they should discuss problem solving with their clients. Lead a discussion for about 5 minutes, then show the contents of the slide.

👤 Say: *You should only discuss problem-solving techniques with your client once you have established that he/she has the will, ability and confidence to take action.*

Problem solving works best when the client is not impaired, meaning he/she is not experiencing withdrawal or substantial cognitive impairment. Otherwise, it will be very difficult for the client to concentrate on the discussion. Even if you develop an action plan at the end of the counseling session, he/she may be unlikely to remember, agree or commit to it if impaired.

It is best to talk about problem solving when the client is in the action or maintenance stages of change, in order to ensure his/her commitment.

You and your client should divide the problem-solving action plan into small steps.

Slide 6

PROBLEM SOLVING

Step 1: Orientation

- Problems are normal and can be solved
- Stop and think
- Don't rush into action

Say: *What can you do as a first step when your client has a problem? How can you help him/her in regular counseling sessions?*

Teaching instructions: Lead a brief discussion among the participants on the questions above.

Say: *It is important to explain to your clients that problems are normal and can be solved. When a problem arises, they should be patient, stop and think before taking any action, and carefully consider the pros and cons of an action before any action is taken.*

Don't rush!

You can teach the client a few steps so that they can solve their own problems. Use an existing problem to help them to practice.

Slide 7

PROBLEM SOLVING

Step 2: Problem definition

- Be specific
- e.g. "My partner does not like me"
 - Too broad
 - Try focusing statement to:
 - "My partner does not like me working late every night"

👤 Say: *It is usually not too difficult to recognize that a problem exists— we often know there is a problem because we feel stressed or find ourselves worrying. It can be much more difficult to define what the problem is. If you spend some time thinking about all the different elements of the situation, you can usually figure out what the problem is. If you've spent some time thinking about it, but still don't have a clear definition of the problem, it may be useful to talk through the problem with someone you trust.*

Clients need to learn how to specify or identify a problem clearly, once they realize that something is wrong. They should collect as much information as possible to help clarify the problem. For example, if the client is upset about his/her current family situation and is thinking about leaving his/her home, you may want to ask the following questions:

"How is your relationship with your family?"

"Have you received any criticism?"

You can ask your client increasingly detailed questions as you focus on the problem. Try to get your client to describe the problem as accurately and specifically as you can.

Slide 8

PROBLEM SOLVING

Step 3: Generate solutions (Brainstorming)

- Every problem has a number of potential solutions
- Anything goes
- Quantity breeds quality
- Don't evaluate

Teaching instructions: : Think of a problem that clearly has more than one solution. Tell the participants some details about the problem, and lead a brainstorming exercise among the participants on possible solutions.

👤 Say: *When brainstorming, the client should come up with as many solutions as possible. Write them all down. Do not reject any ideas, or try to think of just the best idea. You should use your imagination and think of all possibilities. Even ideas that are impractical or not possible may have elements that are useful. Do not evaluate their plausibility until all possibilities have been identified.*

Slide 9

PROBLEM SOLVING

Step 4: Decision making

- Select a short list
- Review pros and cons
- Effective? Possible?
- Select a solution(s)
- Remember: it is the client's choice

👤 Say: Ask the client to consider the pros and cons of each solution he/she considered. For each solution, ask the client to answer the following questions:

- Are there any potential negative consequences (both now or in the near future)?
- How much time will it take to carry this out?
- Is this going to require much money?
- Do you have the skills to carry this out? Do you have the necessary resources?
- Does this require the cooperation of other people, and if yes, are they likely to cooperate?
- Are you likely to face difficulties when carrying out this solution?

The solution you and your client decide upon will depend on the urgency of the problem and the difficulties you both anticipate when implementing the different solutions. In a situation where the problem needs to be dealt with quickly, your client may choose a solution that can be applied right away (even though this might not be the ideal solution).

Consider the consequences: look at each of the alternatives in turn. What things can your client reasonably expect to result from taking each action? What are the positive consequences? What are the long-term negative consequences? What about in the short-term?

The client needs to choose the solutions. Even though the client's choice might not sound the most appropriate to the counselor, it is the most appropriate choice for the client at that point in time. Once the client chooses a solution, he/she will commit to it. This is a very important client-centered principle for you to keep in mind.

If you don't think the client has come up with a good solution, you can suggest he/she think about what he/she might do if the approach does not work, and offer suggestions that you think might be more productive. However, be sure not to allow clients to undertake solutions that appear to be inherently dangerous.

Slide 10

PROBLEM SOLVING

Step 5: Implementation

- Develop a plan of action (including goal setting)
- Try it out
 - Think it through
 - Role-play
 - Real life
- Does it work? Can it be improved?
- Can the client try another strategy?

👤 Say: *Your client needs to put his/her solution into practice in order to address the problem. Many solutions will involve several steps. Break the solution down into these steps, and determine how and when you will carry out each step. This is how your client will set his/her goals.*

Once your client has chosen a solution, you should discuss the next steps and think through their likely efficacy. You might want to role-play the solution before experimenting with the solution in real life. You and your client cannot predict all of the potential difficulties you may face when carrying out your proposed solution. You will need to emphasize the importance of evaluating the solution and trying something else if it is not effective. The progress review will help you identify any persistent problems. You may need to revise your steps or add new ones. Your clients will be more realistic and perhaps optimistic about finding effective solutions to their problems if you can determine a way to measure their success.

You need patience and persistence to solve problems. Always remember to congratulate your clients on both their efforts and progress. The problem-solving method will not make all of their problems go away, nor will it solve all problems. However, with time and practice using this method, you will find that your client is able to cope better and will experience less stress when problems arise.

Slide 11

PROBLEM-SOLVING EXERCISE

- In small groups, apply the problem-solving technique to this problem:
“I never seem to have time to have fun any more.
I am too busy with my work.”

Teaching instructions: Divide the participants into small groups and give them 15 minutes to work through the problem in the slide.

Slide 12

WHAT CAN GO WRONG? (1)	
Obstacle:	Suggestion:
■ Problem poorly defined	■ Be specific
■ Client cannot remember steps	■ Use a variety of teaching methods: explanation, modelling, rehearsal, provide recall aids

👤 Say: *Sometimes, in problem solving, you may encounter some obstacles, like the ones in this slide. The problem may be poorly defined, or your client may not be able to remember all the steps needed to resolve it. In these cases, be sure that there is enough specificity in defining the problem, and/or try to incorporate a variety of teaching methods to help your client recall the steps you discussed.*

Slide 13

Obstacle:	Suggestion:
■ No performance	<ol style="list-style-type: none"><li data-bbox="705 510 1053 600">1. Not consistent with stage of change (client not ready to implement)?<ul style="list-style-type: none"><li data-bbox="705 611 967 672">- Consider motivational interviewing<li data-bbox="705 683 868 712">2. Lack of skill?<ul style="list-style-type: none"><li data-bbox="705 723 1048 813">- Consider cognitive capacity of client and/or use other teaching/recall aids <p data-bbox="705 824 1048 853">Ask what has worked in the past?</p>

👤 Say: *In cases where you are not seeing progress in resolution, consider whether or not the client is really in the appropriate stage of change. If not, consider motivational interviewing to help him/her get there. Otherwise, you may want to consider whether or not your client may lack certain skills to achieve what he/she wants to achieve. In this case, you may want to examine the cognitive capacity of the client, and/or try using other teaching/recall aids.*

Slide 14

WHAT CAN GO WRONG? (3)

Obstacle:	Suggestion:
<ul style="list-style-type: none">■ Counselor begins with problem that is too difficult	<ul style="list-style-type: none">■ When teaching a new skill, commence with easy examples
<ul style="list-style-type: none">■ Evaluation occurs in brainstorm	<ul style="list-style-type: none">■ Explain “rules” clearly

👤 Say: *Sometimes you begin with a problem that may seem too difficult for the client to solve. In these cases, revert to easier-to-solve problems so that your client gains confidence in his/her ability to solve problems.*

In other cases, you may find that your client begins to evaluate solutions during the brainstorm. If this is the case, it will be important to go back to the rules, and explain why it is critical to evaluate only after you have tried a solution.

Slide 15

WHAT CAN GO WRONG? (4)

Obstacle:	Solution:
<ul style="list-style-type: none">■ Slow: counsellor does most of the work	<ul style="list-style-type: none">■ This is common in early stages counsellor is teaching a new skill
<ul style="list-style-type: none">■ Counsellor forgets aim	<ul style="list-style-type: none">■ The aim is to teach the skill to the client - not to solve all the client's problems

👤 Say: *Sometimes the client is slower than you expect and you may end up doing more work than you expected to help solve the problem. This is actually quite common in the early stages of problem solving, and can be expected. Try to move toward doing less work as you begin to solve more difficult problems later on in your sessions.*

Some counselors forget the aim of teaching this technique. Please remember, your job is not to solve all the client's problems, but to help the client learn how to solve his/her problems on his/her own.

Slide 16

SMALL-GROUP EXERCISE

- Groups of three (counselor, client & observer)
- Rotate through the two problems:
 - When I feel upset I end up using heroin
 - When I meet friends I end up using heroin

Teaching instructions: Divide the participants into groups of 3 to consist of “counselors”, “clients” and “observers”. Give the “counselors” the Problem-Solving Worksheet (Handout 5.2-1). Explain that the counselors should guide the clients through the problem-solving steps outlined in this unit, while the observers watch. Clients should be in the problem-recognition stage and identify the problems listed in the slide (one at a time). Counselors should ask clients to describe their problem as accurately as possible, brainstorm solutions, assess alternative solutions, select a solution and make a plan to carry out the solution. After doing one problem, they should switch roles.

Slide 17

SUMMARY

- Many clients have difficulties solving problems
- Teaching them the problem-solving techniques can assist
- Remind clients that problems are normal and can be solved
- Help them clients to be specific in identifying problems
- Identify the best options by looking at pros and- and-cons, plausibility and effectiveness
- Help to think through the implementation process

Teaching instructions: Review the key points of the unit.

FYI:

- Many clients have difficulties solving problems.
- By teaching your clients problem-solving techniques, you can assist them to solve their own problems.
- Be sure to remind clients that problems are normal and can be solved.
- Help your clients to be specific in identifying their problems.
- Identify the best options by looking at the pros and cons, plausibility and effectiveness.
- Help your clients to think through the implementation process.

Teaching instructions: Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.

Handout 5.2-1

Problem-Solving Worksheet

Procedures

Gather information: Recognize that a problem exists. Is there a problem? You get clues from your body, thoughts, feelings, behavior, reactions to other people, and the ways that other people react to you. Think about the problem situation. Who is involved? When does it happen? Exactly what takes place? What effect does this have on you?

Define the problem: Describe the problem as accurately as you can. What goal would you like to achieve? Be as specific as possible. Break it down into manageable parts.

Brainstorm alternatives: List all the things that a person in your situation could possibly do. Consider various approaches to solving the problem. Even list alternatives that seem impractical. Try taking a different point of view; try to think of solutions that worked before, and ask other people what worked for them in similar situations.

Consider the consequences: Look at each of your alternatives in turn. What things could you reasonably expect to result from taking each action? What positive consequences? What negative consequences are long-term? Which are short-term? Which do you think you could actually do?

Make a decision: Which alternative is the most likely to achieve your goal? Select the one likely to solve the problem with the least hassle.

Do it! The best plan in the world is useless if it isn't put into action. Try it out.

Evaluate its effectiveness: Which parts worked best? Reward yourself for them. Would you do anything differently next time? After you have given the approach a fair trial, does it seem to be working out? If not, consider what you can do to beef up the plan or give it up and try one of the other possible approaches. Remember that when you've done your best, you have done all you can do.

Note: The names for the problem-solving steps in this handout might not be exactly the same as those presented in the PowerPoint slides. However, the concepts behind them are the same.

Handout 5.2-1 (cont.)

Practice exercise

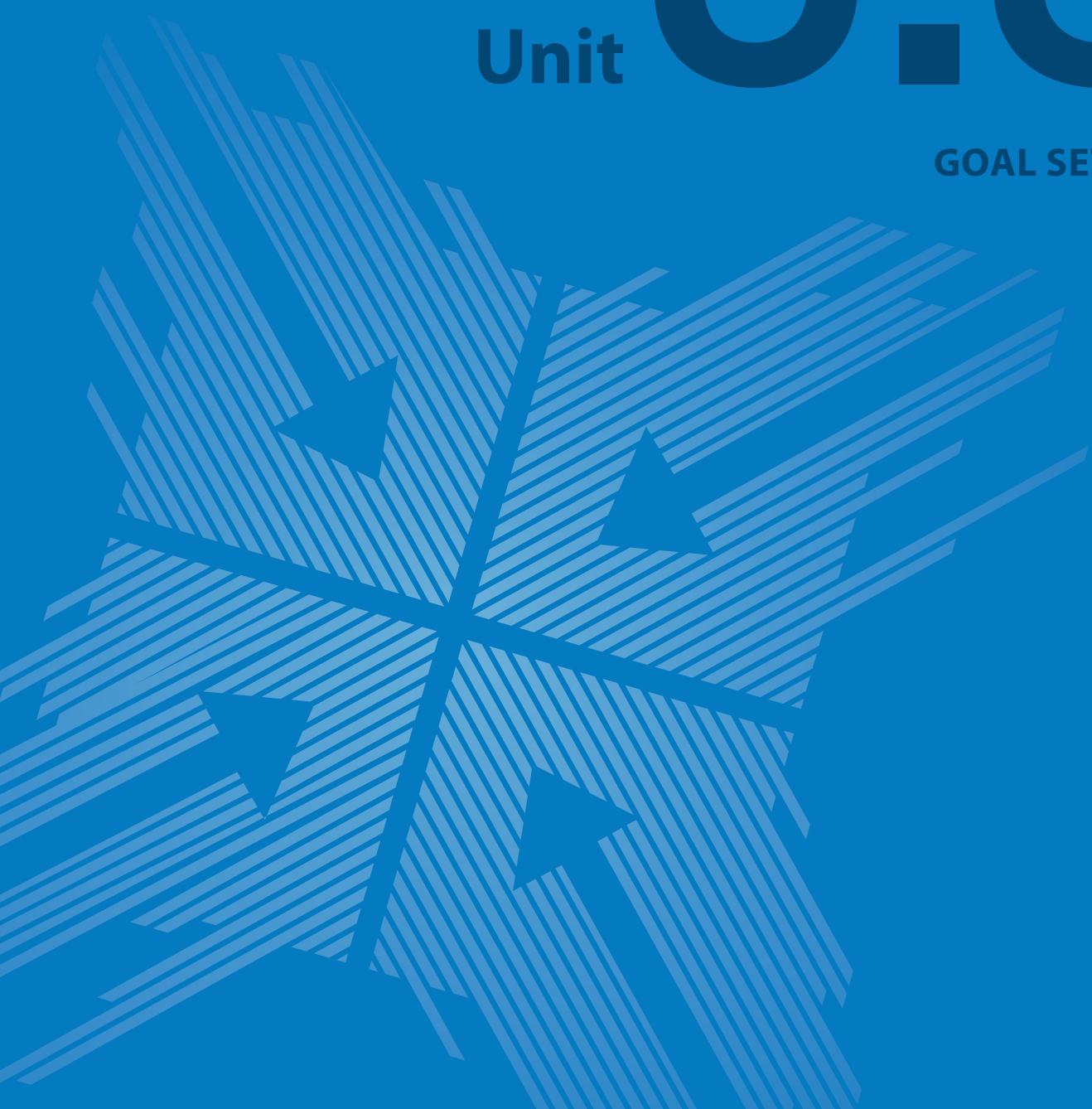
Choose a problem that may arise in the near future. Describe it as accurately as you can. Brainstorm possible solutions. Evaluate the potential outcomes. Prioritize solutions.

Identify the problem situation:		
Brainstorm a list of possible solutions:	Pros:	Cons:
1.		
2.		
3.		
4.		

From: Early Psychosis Intervention Program at <http://www.psychosissucks.ca/epi/>

Unit 5.3

GOAL SETTING



OVERVIEW

Introduction

2 min

Introduce the unit by explaining that you will discuss goal setting, the steps involved, and their application in counseling.

Presentation

45 min

Use the PowerPoint slides to present on goal setting.

Conclusion

8 min

Review the key points of this unit and answer participants' questions (if any).

Unit 5.2: Goal Setting

Goal: To help participants understand the rationale and characteristics of goal setting, the steps involved, and their application in counseling sessions.

Time: 55 minutes

Objective: At the end of this unit, participants will:

- understand the rationale behind goal setting
- understand the main characteristics of goal setting
- understand the use of a structured goal setting method
- be able to demonstrate their knowledge and skills through role-play
- understand the relationship between problem solving and goal setting
- be able to apply goal-setting skills when counseling clients

Methodology:

- Presentation and discussion
- Small-group discussions

Teaching aids:

- PowerPoint slides
- LCD projector
- Handout #5.3-1 Example: Participatory discussion about goal setting and problem solving

Slide 1



👤 Say: *Goal setting is a technique that helps people achieve their goals. It is used by all sorts of people including successful businesspeople, students and athletes, and provides them with short-term motivation and long-term vision.*

The use of a structured goal-setting method can greatly increase your chances of attaining your goals. By setting goals on a routine basis, you decide what you want to achieve, and then move towards the achievement of these goals, step-by-step. By knowing precisely what you want to achieve, you know what you have to concentrate on to do it.

You can also measure and take pride in the achievement of those goals. You can see forward progress in what might previously have seemed a long, pointless grind. You will also raise your self-confidence, as you recognize your ability and competence in achieving the goals that you have set, and in achieving more difficult goals in the future.

Slide 2

LEARNING OBJECTIVES

At the end of this unit, participants will:

- understand the rationale behind goal setting
- understand the main characteristics of goal setting
- understand the use of a structured goal-setting method
- be able to demonstrate their knowledge and skills through role-play
- understand the relationship between problem solving and goal setting
- be able to apply goal-setting skills when counseling clients

Teaching instructions: Use the bullets on this slide to present directly.

Slide 3

SMALL-GROUP EXERCISE

- Questions
 - Why set short-term goals when counseling?
 - What are the main characteristics of short-term goals?

Teaching instructions: Divide the participants into groups of 4 or 5, and give them 10 minutes to brainstorm answers to the questions in the slide. Ask the group to appoint a reporter who will present their findings to the larger group, and allow each group a few minutes to report back.

Slide 4

BENEFITS OF SHORT-TERM GOALS

- Help change appear more achievable
- Help a person experience success and counter learned helplessness
- Help increase confidence
- Encourage further endeavors
- Can act as concrete signposts to guide and measure progress

👤 Say: *Identifying things that can be done in the short - term greatly improves the likelihood that your client will see a way to move forward. People often avoid taking action because they worry that the task is too big. They lock themselves into inactivity because everything seems so big and difficult. They literally feel that they cannot succeed at anything.*

Your client will become more confident that he/she can move forward after achieving a modest success. At this point, you can introduce more complicated activities and requirements.

Remember that short-term goals need to be SMART. This means that you measure your client's performance and provide feedback on his/her achievements. This will reinforce improvement and help your client maintain commitment.

Slide 5

SHORT-TERM GOALS SHOULD BE:

- Geared to the stage of change
 - Not helpful to use action-oriented goals when client is only contemplating change
- Agreed upon
 - Client will be more committed if involved in defining goals
 - Counselor has important role to assist with informed decision making

👤 Say: *The client's short-term goals need to be in line with his/her stage of change. For example, when people are in the contemplation phase, they are still ambivalent about changes in behavior. Therefore, it is important that the client sets more modest and realistic goals. The client's short-term goal could be to move him/her into the action phase. The counselor will need to follow the principles of motivational interviewing and the client will need to agree that the consideration of behavior change is an important short-term goal.*

It is important that clients are at the center of the decision making when you develop short-term goals. What they feel is important for them to achieve should be central to the decision making. Having said that, the counselor has a very important role in decision making. Sometimes goals can be unrealistic and can also be potentially risky in terms of relapse potential. Clients need clinical wisdom to assist them to understand what is realistic. It will be important for you to assist your clients to gain greater insight into their potential vulnerabilities.

Teaching instructions: See the example in Handout 5.3-1 on discussing goal setting and problem solving.

Slide 6

SHORT-TERM GOALS SHOULD BE:

SMART

- Specific
- Measurable
- Attainable
- Realistic
- Time-bound
- Clear, concrete
- Describe presence rather than absence
- Attitudes, abilities and skills to make goal come true
- Success breeds success
- Need a completion date

Teaching instructions: Use the information below to present on the SMART method for establishing goals.

FYI: A good short-term goal needs to be SMART (Specific, Measurable, Attainable, Realistic and Time-bound).

Specific: A specific goal has a much greater chance of being accomplished than a general goal. To set a specific goal, you must answer the six "W" questions:

Who: Who is involved?
What: What do I want to accomplish?
Where: Identify a location
When: Establish a time frame
Which: Identify requirements and constraints
Why: Specific reasons, purpose or benefits of accomplishing the goal

Example: A general goal would be, "Get in shape". But a specific goal would be, "Join a health club and work out 3 days a week."

Measurable: Establish concrete criteria to measure progress towards the attainment of each goal you set. When you measure your progress, you stay on track, reach your target dates, and experience the exhilaration of achievement that encourages you to reach your goal.

To determine if your goal is measurable, ask questions such as, "How much?", "How many?", "How will I know when it is accomplished?"

Slide 6 (cont.)

Attainable: When you identify the goals that are most important to you, you begin to figure out ways you can achieve them. You can then develop the attitudes, abilities, skills, and capacity to reach them. You begin seeing previously overlooked opportunities to bring yourself closer to the achievement of your goals.

You can attain most goals when you plan your steps wisely, and establish a time frame that allows you to carry out those steps. Goals that may have seemed far away and out of reach eventually move closer and become attainable, not because your goals shrink, but because you grow and expand to match them. When you list your goals, you build your self-image. You see yourself as worthy of these goals, and develop the traits and personality that allow you to possess them.

It is also important to ensure that the goals are not only attainable but also agreeable to both parties. Often clients and counselors do not agree on the appropriateness of goals. There needs to be a process of negotiation to ensure both parties are in agreement.

Realistic: To be realistic, a goal must represent an objective that you are both willing and able to work towards. A goal can be both ambitious and realistic; you are the only one who can decide just how ambitious your goal should be. But be sure that every goal represents substantial progress. An ambitious goal is sometimes easier to attain than one that does not seem ambitious, because ambitious goals require more motivation. Those that do not require much motivation may not be of much interest.

Your goal is probably realistic if you truly believe that it can be accomplished. Another way to know whether your goal is realistic is to ask yourself whether you have accomplished anything similar in the past, or to ask yourself what conditions would have to exist to accomplish this goal.

Time-bound: A goal should be grounded within a timeframe. Without a timeframe, there is no sense of urgency. For example, if you want to lose 4 kilograms, but have not set a date by when you will achieve the loss, you may lack the motivation to get started. But if you anchor it with a date, "by May 1st", then you will have a clear sense of how much time you have to achieve it, and you know when you need to start.

Slide 7

THE GOAL-SETTING METHOD

1. List goals and select one or two to work toward
2. Define goals clearly and break them down into small steps
3. Review progress and revise
4. Take satisfaction in efforts and achievements

Teaching instructions: Use the information below to train participants on the Goal-Setting Method.

FYI: 1) List your goals and select 1 or 2 to work towards

Ask your clients to think of all the goals that they have for the next year. Ask “What is it that you want to accomplish?” and “Where would you like to be one year from now?”

If clients initially have difficulties coming up with goals, ask them to think about whether there is anything about their lives that they would like to change, or anything with which they are not happy.

Write down these goals as your clients come up with them. Try to word the goals so that they are positive: “I will pass this course”, rather than “I will not fail this course.”

After thinking about their goals for a while, clients may find that they have many different goals that they want to achieve - this is great! However, working on all these goals at once would leave them with limited time and effort to focus on each, and is likely to make them feel overwhelmed. Take a closer look at the list and prioritize the goals. Try to focus on just one or two earlier on.

When thinking about goals and selecting ones to work on, it is important to be realistic. In order for goal setting to work, goals have to be achievable. Some goals are clearly not realistic - for example, many people would love to find a job where they earn \$100,000/year, but this clearly isn't a realistic goal for most people!

Slide 7 (cont.)

It may be difficult to determine whether some goals are realistic. You can help your client to decide whether his/her goals are attainable by talking openly about them. Setting goals at the right level involves making sure that they are not too difficult or too easy to achieve. It is ideal to set goals that are slightly out of the client's immediate grasp, but not so far that there is little hope of achieving them. It often takes practice to set goals appropriately - and often goals may have to be revised if they begin to appear too easy or too difficult. Do not be disheartened if your client has to revise his/her goals - this is all part of the goal-setting process and is to be expected.

2) Define goals clearly and break them down into small steps

Once the client has selected one or two realistic and achievable goals, he/she will then need to define these clearly. Ask your client to be precise when defining his/her goals - include dates, times and amounts, so that your client can measure his/her achievement.

Divide each goal into small, precise steps. These steps should be ones that the client can attain in a short period of time - over days or weeks. If possible, try to make these steps enjoyable. There are often many different ways to attain the same goal, so choose the most enjoyable way when you can.

3) Review progress and revise

Review your client's progress towards achieving his/her goal regularly. Identify and write down any problems or obstacles that your client encounters.

Engage in problem solving to determine whether there are methods of fixing these problems so that your client can continue working towards the goal as planned. In some cases, the problem may not have an apparent solution, and you will have to revise either the steps towards the goal, or the goal itself.

Do not be disappointed if your client has to revise his/her goals - this is to be expected and indicates that you are using the goal-setting method correctly. When you review your client's progress, note whether he/she is achieving the goal too easily, or if progress is slow, difficult or non-existent. There are no failures in goal setting - just adjustments to the process or to the level of the goal.

Remember that goals may change with the passage of time. Though something may have been a goal six months ago, it may not be a goal today. If goals do not hold any attraction any longer, simply change them or let them go. Goal setting is a tool to help clients achieve the goals they want to achieve.

4) Take satisfaction in your client's efforts and achievements

Clients should celebrate their successes when they achieve their goals. Congratulate your clients - they have worked hard and deserve to feel good about their success!

Slide 7 (cont.)

Their success would not have been possible without effort and without achieving the individual steps towards the goal. Whenever clients achieve a step or make a significant effort toward achieving a goal, take time to let them enjoy the satisfaction of having progressed.

Slide 8

GAUGING COMMITMENT

- The Readiness Ruler
- The Confidence Ruler

👤 Say: You can find out how important your client thinks it is to commit to his/her short-term goal by using the 'readiness ruler'. This is simply a scale with gradations from 1 to 10, where 1 is "not willing to change" and 10 is "extremely willing to change". You can ask your client to rate how important it is for him/her to change.

You might say:

"On a scale of one to 10, where 1 means you are not willing to change and 10 means you are extremely willing to change, how would you rate yourself?"

1	2	3	4	5	6	7	8	9	10
Not willing to change					Extremely willing to change				

The readiness ruler can be used during counseling as a way of encouraging your client to talk about his/her reasons for change.

The same sort of scale can also be used to assess how confident clients are that they can undertake a task. The confidence ruler can be used with clients who have indicated that it is important for them to make a change, or it can be used as a hypothetical question to encourage clients to talk about how they would go about making a change.

You might say:

"How confident are you that you can undertake the task if you decided to do it? On a scale of 1 to 10, where 1 is "not confident at all" and 10 is "extremely confident", how would you rate yourself?"

Slide 8 (cont.)

1	2	3	4	5	6	7	8	9	10
Not confident at all							Extremely confident		

You don't actually need to show the client a ruler, but it may be helpful, especially for clients with low literacy or numeracy skills. For some clients, it may be enough just to describe the scale.

If the client answers 7 or below, ask what is preventing him/her from taking the next step. You can also ask what would need to change for the client to rate his/her chances higher.

Slide 9

SMALL-GROUP EXERCISE

- Groups of three: counselor, client and observer
- Apply the goal-setting technique to this problem:
 - “When I meet friends I end up using heroin”

Teaching instructions: Divide the participants into groups of 3 and have them each assign themselves as either “counselors”, “clients” or “observers”. The counselors should guide the clients through the goal-setting steps as discussed, while the observers watch. Reconvene the group and together check the goals against the SMART criteria (large-group exercise). Ensure that all elements are present and all participants agree.

Slide 10

SUMMARY

- Short-term goals are important for moving forward
- Define goals clearly and break into small steps
- Determine commitment through the use of the readiness ruler
- Review progress in order to revise goals as necessary
- Support your clients for undertaking difficult tasks

Teaching instructions: Review the key points of the unit.

FYI:

- Short-term goals are important for moving forward
- Define goals clearly and break into small steps
- Determine commitment through the use of the readiness ruler
- Review progress in order to revise goals as necessary
- Support your clients for undertaking difficult tasks

Teaching instructions: Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.

Handout 5.3-1 (This sheet for trainers only)

Example: Participatory discussion about goal setting and problem solving

Trainer: *I want to talk about goal setting. What is goal setting? Why do we set short-term goals and what are the characteristics of goal setting? Who can give me some ideas about this?*

Participant: *Goal setting is a technique we can use to help us achieve our goals over a certain period of time.*

Trainer: *Very good. How do we set goals?*

Participant: *I think we should set goals over the short-term so we can solve the problem easier.*

Trainer: *If we are going to do that, how can we teach people about goal setting? What are the characteristics of goal setting that need to be considered?*

Participant: *It may not be possible to achieve the goal quickly, so we should break it down into smaller goals to make it more achievable.*

Participant: *I think it is like building a house.*

Trainer: *OK. Small goals are easier to develop and achieve than big goals. And short-term goals are achievable and realistic. So what are some other characteristics of short-term goal setting?*

Participant: *Short-term goal setting is more suitable to the client because it's easier and more feasible for the client.*

Trainer: *Feasibility is very important in goal setting.*

Participant: *And the clients don't have to spend a lot of time to achieve it.*

Trainer: *OK. So it can be done in a short time.*

Participant: *I think goals can get too big, but when we break them down into smaller goals, the clients feel more confident that they can achieve the smaller goals.*

Trainer: *OK. So confidence can be very important to assist the client to move forward.*

Participant: *Smaller goals are easier for us to evaluate, adjust and observe the result.*

Trainer: *Yes. Evaluation is very important. I agree.*

Handout 5.3-1 (cont.)

Participant: *When the client achieves each smaller goal, they feel more confident each time and are motivated to keep going.*

Trainer: *I agree, and we said that confidence is important.*

Participant: *It prevents the client from feeling fed up about his/her attempts to reach the goal, and encourages the client to keep going.*

Trainer: *So it encourages the client to continue. Anything else?*

Participant: *It helps us to recognize the client's progress.*

Trainer: *Ok. Tell me some more about that. What do you mean by that?*

Participant: *When they have a smaller goal and they achieve it, they can see their progress. They are then closer to reaching the long-term goal.*

Trainer: *OK. Another way to say what you said is that the goal is positive, it moves the client forward in a positive direction.*

Participant: *One of the characteristics of the short-term goal is that it forms the foundation for clients to continue to reach the long-term goal.*

Trainer: *That's true. Short-term goal setting allows the client to move step-by-step towards a long-term goal. It's quite true. The Chinese have a saying: "Each journey begins with a single step." The journey is the long-term goal.*

Participant: *It also allows the client to review whether the long-term goal is correct.*

Trainer: *Ok. Yes, it is important to evaluate and review your steps to make sure you are moving forward. Setting short-term goals helps you to make things more achievable. It helps to give the client confidence to go on. It will encourage the client to move on to more complicated things and continue. Evaluation gives them a concrete way of saying "Yes, things are getting better, I am doing well." As with problem solving, the client needs to be in the action phase for goal-setting to work. It will be difficult for the client to set goals if he/she is a pre-contemplator.*

You will need to determine how committed the client is to achieving the goal. There are two aspects of commitment: willingness and confidence. Problem solving and goal setting are usually linked, because once you have identified the problems and their possible solutions, you identify the goals your client wishes to achieve.

Handout 5.3-1 (cont.)

(Role-playing)

Trainer: Before we discuss goal setting, what are some of the problems that you tend to face in your role-plays?

Participant: All of the clients insist that the only way that they can solve their problems is by using drugs.

Trainer: Yes. So what does that mean? What can you tell from that? What stage of change are they in?

Participant: Pre-contemplation.

Trainer: That's right. Remember that it's more difficult and complicated for pre-contemplators to solve problems or set goals. So what are the problems for you as counselors?

Participant: It is very difficult for counselors to practice 90% listening and 10% talking.

Trainer: Why is this so difficult?

Participant: Because when we ask a question, the clients don't know what to say, or they try to give very short answers.

Trainer: It is difficult because the clients often believe that other people will solve their problems, or they are used to other people telling them what to do. They don't have much practice at giving opinions or expressing their point of view.

Remember that you are not there to solve the clients' problems; you are teaching them how to solve problems. It's probably helpful for you to know that a drug counselor who is experienced at assessing clients will take somewhere between 45 minutes and an hour. Once you have assessed the client and he/she is already engaged with you, an individual counseling session will usually be about 45 minutes. Whether you are setting goals, solving problems, preventing relapse or whatever, the client will get very tired and withdraw from the conversation if you spend more than 45 minutes on a session. If the session is any shorter, then the client may have just started to develop something when you say it's finished, it's time to go.

Source: Early Psychosis Intervention Program <http://www.psychosissucks.ca/epi/>

Unit 5.4

REDUCING RISK



OVERVIEW

I. Introduction

1 Min

Introduce the unit by explaining that you will discuss the key concepts of risk reduction and overdose prevention as they are applied in drug addiction counseling.

II. Presentation

55 Min

Use the PowerPoint slides to present on risk reduction.

III. Conclusion

4 Min

Review the key points of this unit and answer participants' questions (if any).

Unit 5.4: Reducing Risk

Goal: To help participants understand the basic principles of risk reduction counseling and overdose prevention as they are applied in drug addiction counseling.

Time: 60 minutes

Objectives: At the end of this unit, participants will:

- understand the definition of risk reduction
- understand the principles of risk reduction
- understand and practice safe injection and safe disposal of used needles and syringes
- know the basics of vein care
- know the basics of prevention of overdose

Methodology:

- Presentation and discussion
- Demonstration and practice

Teaching aids:

- PowerPoint slides
- LCD projector
- Flipchart and paper
- Markers

Slide 1



👤 Say: *While the long-term goal of counseling drug users is to support them to stop using drugs, drug addiction is a chronic, relapsing brain disorder, so it is likely that clients will need to go through multiple episodes of drug treatment before they can remain drug-free. It is critical to provide information about risk reduction to your clients to minimize the possible risks associated with drug use.*

Slide 2

LEARNING OBJECTIVES

At this end of this unit, participants will:

- be able to define risk reduction
- understand the principles of risk reduction
- understand and practice safe injection and safe disposal
- know the basics of vein care
- know how to prevent and deal with overdose

Teaching instructions: Use the bullets on the slide to present directly.

Slide 3

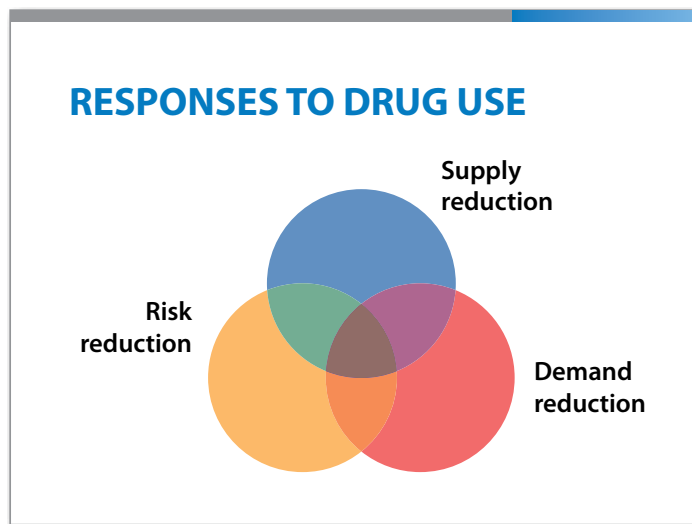
RISK REDUCTION

Aims to reduce the adverse health, social and economic consequences of alcohol and other drugs by minimizing or limiting the harms and hazards of drug use for both the community and the individual.

(Lenton & Single 1998)

👤 Say: *Risk reduction can be a policy or program directed toward reducing or containing the adverse health, social, and economic consequences of alcohol or other drug use (AADAC, 1998). It may also be a set of non-judgmental strategies and approaches that aim to provide and/or enhance the skills, knowledge, resources and support that people need to live safer, healthier lives. The design of risk reduction strategies needs to reflect individual and community needs.*

Slide 4



Teaching instructions: Use the information below to explain the three main interventions used to address drug use.

FYI: Attempts to restrict illicit drug supplies are costly, produce substantial unintended negative consequences, and have rarely produced significant and sustained reductions in drug-related problems. The restriction of the drug supply only helps reduce drug problems when the demand for drugs is low, detection is difficult to evade, and substitutes are not readily available. This suggests that reducing the supply of drugs will only become a successful strategy for decreasing the harm associated with drug use when effective demand-reduction strategies are also implemented.

HIV-prevention strategies for injecting drug users (IDUs) are developed and implemented in the context of efforts to decrease drug use, and meet drug users' other needs, such as primary health needs, and human rights. Effective drug education can decrease experimentation with drugs. At the same time, it can also ensure that those who do experiment have the knowledge necessary to prevent the risks associated with drug use, especially HIV transmission. Law enforcement can effectively target major drug suppliers while participating in public health approaches for drug users. Thus, police forces can play an important role in the prevention of HIV transmission. In some countries, police actively participate in risk reduction by referring drug users for treatment, rather than arresting them, and even providing them with clean needles and syringes.

Imprisoning drug users simply for using drugs does not diminish demand for the drugs. It potentially causes major harm to the individual, who is often exposed to increased risk in prisons (including a higher risk of HIV infection) while lacking treatment for drug problems.

Slide 4 (cont.)

Independent of each other, the three different approaches of supply, demand and risk reduction cannot be regarded as singularly effective. However, together they can complement each other - resulting in a favorable environment in which it is possible to contain the problem of illicit drug use, and address the HIV/AIDS epidemic among IDUs.

Examples:

- Supply reduction:
 - Law
 - Policies
 - Crop reduction
 - Prison
- Demand reduction
 - Media campaign
 - Treatment
 - School education
- Risk reduction
 - NSP (Needle/syringe exchange/distribution programs)
 - Condoms
 - Peer education
 - Family support

Slide 5

RISK REDUCTION RECOGNIZES THAT:

- Many people use drugs (of one kind or another)
- Many people do not want to stop using drugs
- There are different levels of harm a drug can cause
- The risks of drug use can be reduced
- The risk reduction approach does not promote use
- Risk reduction encourages drug users to lower risk and thus reduce the harm associated with drug use

Teaching instructions: Use the bullets on the slide to present directly.

FYI: Philosophy of risk reduction

Risk reduction is one of the most effective tools for addressing the health and social problems related to risky activities. Risk reduction approaches are catered to where clients stand in terms of their drug use — respecting and supporting their ability to make decisions. One of these decisions may be to use drugs or to engage in other high-risk behaviors. People begin to use drugs for many reasons. If you have a client who does not choose abstinence, you, as a care provider, can provide options and support to minimize the negative consequences (harm) that may result.

Drug problems occur along a continuum of risk, ranging from minimal to extreme. You cannot stop a client from using drugs, but you can help clients reduce the risks associated with their drug use. A risk reduction philosophy allows you to maintain the same level of availability, quality of service and treatment that you provide to others who may not be using drugs. It means you provide your service without discrimination.

One of the key roles of health and social care providers is to help people live healthier lives. Care providers need to recognize that small improvements in a person's health can pave the path for further reductions of drug use and improved lifestyle. Risk reduction strategies encourage people to build on their strengths and to gain a sense of confidence. They can help someone move from a state of chaos to one of control.

Slide 6

RISK REDUCTION PRINCIPLES

Features of risk reduction:

- Pragmatic
- Prioritizes goals
- Has humanist values
- Focuses on risks and harm
- Does not focus on abstinence
- Seeks to maximize the range of intervention options that are available

Teaching instructions: Use the information below to explain the various principles of risk reduction.

FYI: The following principles of risk reduction are adapted from those established by The Canadian Centre on Substance Abuse (CCSA 1996), and Lenton and Single - 1998.

Pragmatic: Risk reduction accepts that the use of drugs is a common and enduring feature of the human experience. It acknowledges that, while carrying risks, drug use provides the user with benefits that must be taken into account if responses to drug use are to be effective. Risk reduction recognizes that the containment and reduction of drug-related harm is a more feasible option than efforts to eliminate drug use entirely.

Prioritizes goals: Risk reduction responses to drug use incorporate the notion of a hierarchy of goals. The immediate focus is on actively engaging individuals, target groups and communities to address their most compelling needs through the provision of accessible and user-friendly services. It is essential to achieve the most immediate, realistic goals as a first step toward risk-free use, or, if appropriate, abstinence.

Humanist values: The drug user's decision to use drugs is accepted. No moral judgment is made either to condemn or support drug use. Drug users' dignity and rights are respected, and services endeavor to be "user-friendly". Risk reduction approaches also recognize that, for many, drug addiction is a long-term part of their lives and that responses to drug use must accept this.

Slide 6 (cont.)

Focus on risks and harm: By providing responses that reduce risk, harm can be reduced or avoided. Risk reduction interventions usually focus on the drug-taking behavior of the drug user. However, risk reduction recognizes that people's ability to change their behavior is also influenced by the norms held in common by drug users, and the attitudes and views of the wider community. Risk reduction interventions may target individuals, communities and even broader populations.

Does not focus on abstinence: Although risk reduction supports those who seek to moderate or reduce their drug use, it neither excludes nor presumes a treatment goal of abstinence. Risk reduction approaches recognize that short-term abstinence-oriented treatment programs have low success rates, and, for opiate users, high post-treatment overdose rates.


Maximizes the range of intervention options that are available: Risk reduction programs help to identify, measure and assess the relative significance of drug-related harm and balance the costs and benefits in trying to reduce them.

Source: CCSA (1996) Risk reduction: Concepts and Practice: A Policy Discussion Paper, Canadian Centre on Substance Abuse (CCSA) National Working Group on Policy. Lenton, S. and Single, E. (1998) The definition of risk reduction. *Drug & Alcohol Review* 17, 2: 213-220.

Slide 7

RISK REDUCTION STRATEGIES

- Needle and syringe exchange/distribution programs
- Methadone maintenance programs
- Education and outreach programs
- Law enforcement policies

 **Say:** Risk reduction strategies can be applied to a range of high-risk behaviors. Examples of risk reduction strategies targeting drug use include:

Needle and syringe programs: The provision of sterile needles and syringes is a simple, cost-effective way to reduce the risk of spreading HIV and hepatitis C to the population at large. These programs provide a broad range of services and support beyond the distribution and/or exchange/provision service. The syringe service provides an excellent mechanism for reaching and providing support to hard-to-reach populations.

Methadone maintenance programs: Methadone is a synthetic opioid available to people who are addicted to opiates such as heroin. It effectively blocks the cravings for heroin without the euphoric effects of heroin. It is relatively safe, non-toxic and has minimal side effects. People can be treated safely with methadone for years. Individuals addicted to heroin who are on methadone can live balanced and productive lives. They are able to secure jobs, raise families and fully participate in their community. Drug-replacement programs for other substances are being researched.

Education and outreach programs: Drug education materials with a risk-reduction focus that target at-risk populations can help initiate positive change. These materials can include information on the safer use of drugs, how to improve overall health, and can highlight some of the negative consequences of drug use. Outreach workers and other service providers can distribute risk-reduction educational materials along with the provision of their other services. Sample risk reduction educational materials are included in the Risk Reduction Information Kit included with this training.

Law-enforcement policies: Criminalization has long been the general approach towards drug use, although this is now under public debate throughout the world. Shifts toward community policing, public advocacy for access to treatment, and review/revision of legislation, may allow for the application of more risk reduction measures by enforcement authorities in the future.

Slide 8



👤 Say: *Intravenous injecting is a highly efficient way to introduce drugs into the body. However, injecting bypasses the filtering and delaying mechanisms that protect us when things are absorbed through the gastrointestinal tract, lungs or skin. This makes injecting the most hazardous way of introducing drugs into the body. Injecting increases the potential of infection and overdose, as compared to other routes.*

A large body of research shows that injecting is associated with increased levels of drug addiction and increased health risks from:

- *blood-borne viruses*
- *bacterial infections*
- *fungal infections*
- *damage to the circulatory system*
- *increased likelihood of overdose*

Although the best way of reducing the harm associated with injecting is not to inject, it is clear that many IDUs do not want to stop, and tend to evade interventions and treatment that primarily seek to stop them from injecting.

IDU services have to provide appropriate information and support on how to reduce a range of injection-related risks.

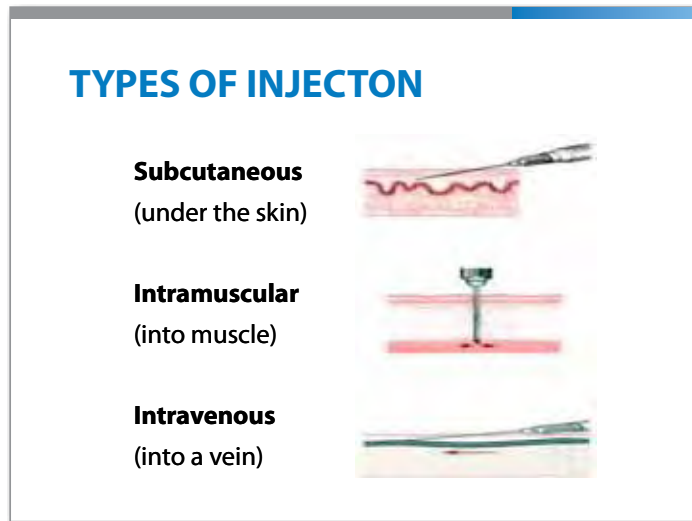
Most information and advice for drug users focuses on preventing the sharing of needles and the transmission of blood-borne viruses such as hepatitis B and C, and HIV. However, many injecting drug users experience injection-site problems such as infections and physical damage, and most do not seek appropriate treatment for them unless they become serious.

Slide 8 (cont.)

This results in greater levels of permanent damage, and the injecting drug user requiring more intensive and expensive treatment.

It is important that counselors are able to give advice to reduce the incidence of problems at injecting sites, and to encourage appropriate help-seeking when they do occur. Although it would be desirable to have staff with nursing and/or medical expertise available within all counseling facilities, this is not practical for many services. However, provided they have the knowledge and confidence, counselors can provide clear and useful advice on preventing and responding to local injuries and infections, and on ways of reducing injecting damage.

Slide 9



Say: *There are three types of injection. If the injection penetrates just under the skin, it is subcutaneous. If it goes deeper into the muscle, it is intramuscular. Most injecting drug users who use illegal drugs prefer to inject directly into the vein, which is called intravenous injection.*

Slide 10

NEEDLES – KEY POINTS

Bevel: sloping edge

Bore: hole

Gauge: measure of thickness



Slide under the skin at a shallow angle with the bevel facing up

👤 Say: *It is easier to inject into a vein if the bevel is facing upwards and the needle is introduced to the skin at about a 20° angle. This makes it easier for the needle to penetrate the skin and enter the vein. When the needle is in the vein, you will be able to see blood at the base of the barrel of the syringe.*

Slide 11

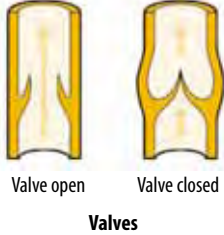
VEINS AND ARTERIES

Veins

- carry blood towards heart
- carry oxygen-depleted blood
- dark red blood
- thin walls/not elastic or muscular
- valves
- no pulse – ooze blood

Arteries

- carry blood away from heart
- carry oxygen-rich blood
- bright red blood
- thick walls, very elastic/muscular
- no valves
- recognizable pulse – spurts blood



Valve open Valve closed

Valves

Teaching instructions: Use the information below to explain the features of veins and arteries.

FYI: Arteries take oxygenated blood from the lungs to the rest of the body. They progressively branch out, diminishing in size, until they reach the capillaries.

The blood then passes through the capillaries in the tissues, releases its oxygen, and is collected in small veins, which, by joining together, progressively increase in size. The veins return de-oxygenated blood to the lungs after it has passed through the heart.

Accordingly, all drugs injected into veins must follow a route back - through veins of increasing size - to the heart. From the heart, the drugs are pumped the short distance to the lungs where the blood passes through the capillaries of the lungs to be re-oxygenated. The oxygenated blood then returns to the heart to be pumped to the brain and other body tissues.

When a drug is injected into a vein, it reaches the brain via the lungs in a short time (about 15-20 seconds). The drug is not significantly diluted: hence the experience of the "rush" or "hit" as the brain rapidly becomes intoxicated.

Valves are only present in veins, and assist the flow of blood back to the heart by preventing back flow (see figure in slide).

Arterial injection

All injecting drug users should be warned that they should never inject into a blood vessel in which they can feel a pulse. It is very dangerous to inject into arteries and can be potentially lethal.

Slide 11 (cont.)

Although most arterial injections are accidental, occasionally people attempt arterial injection deliberately. The practice of deliberate arterial injection should be strongly discouraged.

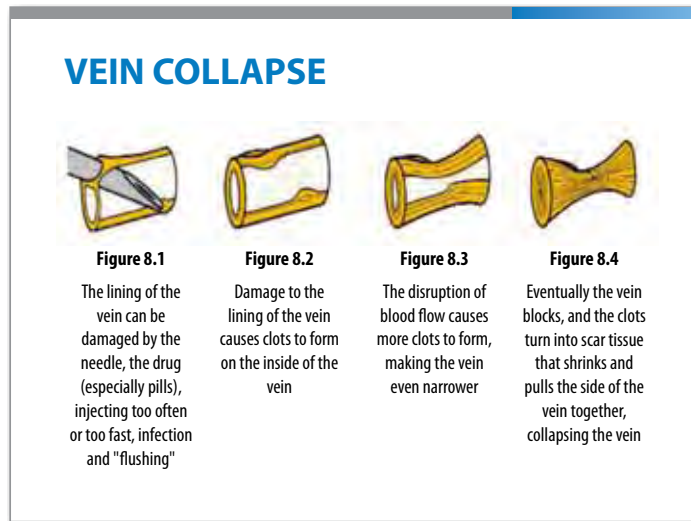
For drug users who hit an artery by mistake or otherwise, your advice should be to:

- *withdraw the needle immediately - do not complete the injection*
- *put strong pressure on the site for at least 15 minutes, raise the affected limb if possible, and seek medical advice*

Why it is dangerous to inject into artery:

- Air injected into artery can block blood flow and kill you
- Extreme blood loss can occur (blood in arteries is under high pressure)
- Artery spasm can cause the limb to die
- Can cause extreme pain

Slide 12



Say: Blood clots form when there is turbulence in the blood flow. Damage to, or inflammation of, the lining of the vein (Figure 1) can trigger blood clots at the site of injection (Figure 2).

These clots stick to the lining of the vein, and are known as a thrombus. The clots themselves cause turbulence. The turbulence can cause further clotting (Figure 3).

A blood clot inside a vein does the same things as a blood clot on the surface - it hardens and turns to scar tissue that shrinks and pulls the edges together (Figure 4).

It is this pulling together of the edges that makes veins "collapse".

Veins that have collapsed in this way do not "unblock" - the blood has to find another way back to the heart.

Veins may become temporarily blocked if the internal lining of the vein swells in response to repeated injury or irritation. This may be caused by the needle, by the substance injected, or both. Once the swelling subsides, the circulation will often re-establish itself.

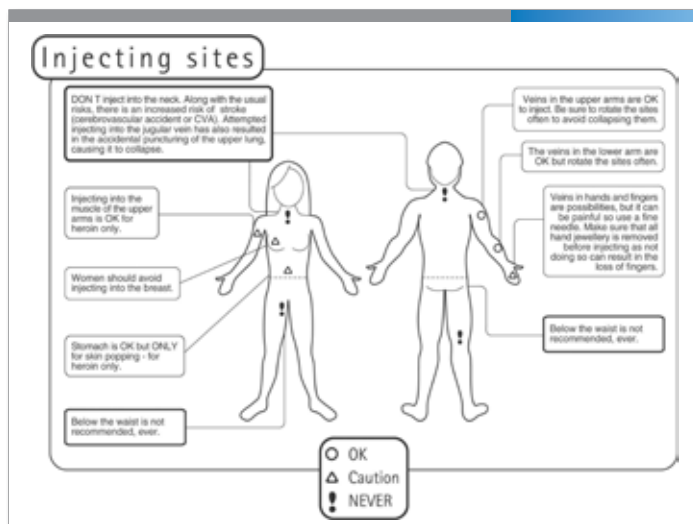
Smaller veins may block as a consequence of too much suction when the drug user pulls back against the plunger of the syringe to check that the needle is in the vein. This will pull the sides of the vein together (especially if they are inflamed) and the sides of the vein may stick together, causing the vein to block. Removing the needle too quickly after injecting can have a similar effect.

Slide 12 (cont.)

Permanent vein collapse (Figure 4) can occur after:

- *long-term injecting*
- *repeated injections, especially with blunt needles*
- *poor injecting technique*
- *injection of substances that irritate the veins*

Slide 13



Say: This diagram identifies a range of injecting sites that are commonly used by injecting drug users. Veins in the upper arm and forearm are OK, but they should be rotated. Veins in the hands, groin and armpits are potentially dangerous because of their proximity to major arteries that the drug user could inject into by mistake. Drug users should be advised never to inject below the waist as there is a greater risk of injecting into arteries.

Slide 14

Long-term consequences of vein damage

- Ulcers: broken-down skin
- Abscesses: localized areas of pus within inflamed tissue
- Phlebitis: irritation of smooth inner lining of vein
- Cellulitis: painful inflammation of the skin
- Gangrene: death of body tissue

Seek medical advice

- Infection: Hep C/HIV, bacterial, fungal
- Missed hits: swelling around injection site
- Scar tissue: collapsed veins
- Lumps and bumps under the skin

Teaching instructions: Use the information below to present on the long-term consequences of substantial vein damage.

FYI: A number of problems can arise when the flow of blood through the limbs has been severely affected. These include:

- ulcers: broken down skin
- abscesses: localized areas of pus within inflamed tissue
- phlebitis: irritation of a vein's smooth inner lining
- cellulitis: painful inflammation of the skin
- gangrene: death of body tissue

Ulcers

One possible result of the serious deterioration of circulation can be painful areas of broken skin, known as ulcers. Ulcers form when the skin is knocked or scratched (or injected into) and the surface is broken. The slow flow of blood means that the cells cannot reproduce quickly enough to heal the wound. The resulting moist and painful wound can take years to heal, and can be compounded by infection.

Abscesses

An infected abscess is a localized collection of pus that is encapsulated within inflamed tissue. It can be caused by a wide range of bacterial and fungal infections. An abscess is different from cellulitis in that it has a defined edge and shape.

Slide 14 (cont.)

An abscess is characterized by:

- raised skin surface
- localized heat
- tenderness and pain
- redness of the skin (in white people)
- pus formation
- a foul smell if it has begun to discharge

People with abscesses should be referred for medical advice and treatment. The abscess will require antibiotic treatment and/or lancing to release the pus. Injecting drug users should be told never to try to lance or puncture abscesses themselves. This can spread infection and, without appropriate antibiotics, they can quickly develop septicemia (blood poisoning). They should be encouraged to alternate injecting sites as this will lessen the risk of localized inflammation, infection and abscess formation.

Phlebitis

Phlebitis is an irritation of the smooth inner lining of a vein, making it rougher. The roughening of the vein lining can encourage the formation of clots. The vein is reddened or inflamed and can sometimes be felt as a thick cord beneath the skin.

Phlebitis can occur as a result of:

- injecting irritant substances (such as pills, etc).
- poor injecting technique
- infection
- accidental injury (i.e. knocks or blows)

An important complication of phlebitis is deep vein thrombosis (DVT), which can lead to pulmonary embolism. If phlebitis is suspected, the person should be referred for immediate medical advice. Treatment includes resting and raising the limb, antibiotics and anti-inflammatory drugs.

Cellulitis

Cellulitis refers to a painful, spreading inflammation of the skin, which appears red and swollen with fluid (this is known as edema).

Cellulitis can occur as a result of:

- irritant substances lodged in body tissues
- serious infection

Slide 14 (cont.)

When cellulitis is suspected, the client should be referred for immediate medical advice. Treatment includes resting and raising the affected limb, and treatment with antibiotics and anti-inflammatory drugs.

People who have had cellulitis should take the following steps to prevent it in the future:

- use sterile injecting equipment
- use sterile water where available and discuss alternatives where it is not
- avoid the injection of irritating or heavily adulterated drugs
- remove rings prior to injecting, if injecting in the hands

Gangrene


Gangrene is the death of body tissue caused by impaired or absent blood supply. Gangrene can occur as a result of serious damage to the veins or arteries.

The effects of gangrene can be disastrous, leading to the loss of limbs. It can also cause the products of tissue breakdown to enter the bloodstream, causing blood poisoning. Gangrene can be life-threatening.

Slide 15

VEIN CARE

- Use a new sterile needle & syringe every time
- Use smallest size needle (27G)
- Clean injection site
- Go slow and be gentle
- Rotate sites
- Learn to inject in both arms
- Don't inject where there is redness, swelling & pain
- Never inject pills
- Maintain a healthy diet & adequate sleep

 **Say:** *Simple vein care methods can prevent vein damage. Be sure to train your clients to follow these steps:*

- *use a new sterile needle and syringe every time*
- *use the smallest size needle (27G)*
- *clean the injection site before injection*
- *go slow and be gentle*
- *rotate sites of injection*
- *learn to inject in both arms*
- *don't inject where there is redness, swelling and/or pain*
- *never inject pills*
- *ensure that you maintain a healthy diet and adequate sleep*

Slide 16



👤 Say: *This is a typical track mark due to intravenous heroin use. The person is pointing to a slight inflammation (red line) up the arm. This is thrombophlebitis - an inflammation of the vein.*

Slide 17



Say: *This slide shows extensive “track marks” from intravenous drug use.*

Slide 18



👤 Say: *The slide shows infection from intravenous drug use. The client has been treated for one week on antibiotics. The site still shows an open lesion and cellulitis.*


Slide 19



👤 Say: *This slide shows a venous abscess from intravenous drug use. Infections may also include septicemia (referring to the presence of pathogenic organisms in the blood-stream, leading to sepsis) or a septic joint in intravenous drug users. Hot, painful joints should be assumed to be septicemia until proven otherwise.*

Slide 20

OVERDOSE

 **Say:** *Now let's discuss overdose.*

Slide 21

OVERDOSE – INTRODUCTION


- **Overdose is now the largest cause of death amongst injecting heroin users.**
- Many drug users overdose because they don't realize the risks they are taking when they inject heroin and use combinations of heroin and other drugs (including alcohol).
- Many deaths happen because people who see overdoses often don't know WHAT TO DO to help.

👤 Say: *Overdose is now the leading cause of death among injecting heroin users. Taking heroin when intoxicated from other depressants that act on the central nervous system, such as alcohol or benzodiazepines, can enhance the toxicity of heroin and cause a fatal overdose.*

Slide 22

HOW AND WHY OVERDOSES HAPPEN

- When injecting drugs
- When you take too much of a drug OR a combination of drugs (some combinations can be DEADLY: heroin & alcohol, heroin & downers)
- Anyone who uses drugs can overdose (from first-time users to veterans)
- When using opiates when tolerance is low (it only takes a few days for tolerance of opiates to drop)
- After a week or so without opiates, a dose that at one time wouldn't have touched you can kill you.

 **Say:** *Let's discuss the main things that cause overdose. They include....*

Injecting drugs - *Injecting heroin users are about 14 times more likely to die than the general population. People who inject heroin are much more likely to overdose than people who smoke it.*

Mixing drugs and alcohol - *Most overdoses happen when people have alcohol or downers, such as valium and temazepam, in their system when they inject heroin. These sedative drugs combine to depress the central nervous system and breathing. People can literally stop breathing.*

Using opiates when tolerance is low - *It only takes a few days for a drug user's opiate tolerance to drop. After a week or so without opiates, a dose that wouldn't have had much of an effect on you at one time can kill you.*

People who have often overdosed before and survived can still die from an overdose. It is not normally "new users" who overdose; it is usually people who have been injecting for years.

Sometimes overdoses are not accidental. Feeling depressed, hopeless, or not caring whether you live or die can all make an overdose more likely. Talking about feelings is important and can help reduce the risk of a non-accidental overdose.

Slide 23

OVERDOSE RISKS

- Not knowing the *quality* of drugs
- Not knowing body *tolerance*
- *Mixing* drugs (multiple drug use)
- Using *alone* (no one to rescue you)

Teaching instructions: Use the bullets on this slide to present directly.

Slide 24

RECOGNIZING OVERDOSE

- Respiratory depression
 - very slow; ultimately no breathing
- Cyanosis
 - turning blue on the lips and fingertips (first)
- Extreme somnolence
 - hard to wake: sleepiness

👤 Say: *If someone has overdosed, put him/her in the recovery position and keep watching him/her. You need to know if he/she is unconscious. You can figure this out by rubbing your knuckles on his/her sternum - the center of the rib cage.*

Other signs include if you can't wake the patient or he/she shows other signs of unconsciousness, such as:

- *snoring deeply*
- *turning blue*
- *not breathing*

Slide 25

OVERDOSE EMERGENCY: WHAT TO DO

- Stay CALM
- ABC
 - Airway
 - Breathing & Pulse
 - Circulation
- Not breathing: Do rescue breathing
- Not breathing, no pulse: Do chest compression (and rescue breathing)
- Breathing and pulse: Recovery position - to protect from blocking the airway & choking on vomit

👤 Say: Remember to stay calm. If the person is not breathing, provide rescue breathing. If the person has no breathing and no pulse, provide chest compressions and rescue breathing. If the person has both breathing and pulse, then maintain him/her in the recovery position and protect him/her from choking on his/her own vomit. The ABC approach involves checking the following:

A. Airways: Open the airways by lifting the chin and tilting the head back. Open the mouth. If it is blocked by anything, including vomit, tilt the head to one side and clear the mouth.

B. Breathing: Put your ear by his/her mouth and look down the length of the body. Take no more than 10 seconds to look, listen and feel for signs of breathing.

C. Circulation: Look for signs of circulation such as breathing, coughing or movement. Take no more than 10 seconds.

FYI: Cardiopulmonary resuscitation (CPR) is a technique of rescue breathing combined with chest compressions. The purpose of cardiopulmonary resuscitation is to maintain sufficient circulation to preserve brain function until specialized treatment is available. Rescuers should start CPR if the victim has no signs of life (unconscious, unresponsive, not moving and not breathing normally). There should be thirty compressions of the chest followed by two ventilations. The compression rate should be about 100-130 compressions per minute. If this is combined with two breaths (each given over one second per inspiration) there should be five cycles approximately two minutes. Then check if the person is breathing and/or has a pulse. If not, repeat the cycle again.

This link provides quick and easy instructions and diagrams:
<http://depts.washington.edu/learncpr/quickcpr.html>

Slide 26



Say: *The following steps are those you should take to place someone in the recovery position.*


- 1. Make sure there are no foreign objects in the mouth (e.g., loose dentures, vomit) by looking in the mouth and removing any obstructions*
- 2. Open the airway by tilting the head back and lifting the chin. Straighten the legs*
- 3. Place the arm nearest to you at right angles to the body*
- 4. Pull the arm furthest from you across the chest*
- 5. Hold the leg furthest from you above the knee and move it upward across the leg*
- 6. Ensure the back of the hand is placed against the cheek nearest to you*
- 7. Keep the hand pressed against the cheek and pull on the upper leg to roll the patient towards you and onto his/her side*
- 8. Tilt the patient's head back to ensure he/she can breathe easily*
- 9. Ensure the hip and knee of their upper leg are bent at right angles*

Teaching instructions: Invite a volunteer to demonstrate these steps and then ask participants to practice in pairs.

Slide 27

WHAT NOT TO DO IF AN OVERDOSE HAPPENS

- **DON'T** walk the person around – they may **fall!**
- **DON'T** put the person in a **bath** or **shower** – they could **drown** or **die of hypothermia!**
- **DON'T** check whether they are conscious by **hurting** them
- **DON'T inject them** with salt water, milk, or other drugs (such as cocaine or speed)

 **Say:** *There are a few things that you should never do during an emergency overdose.*

Don't walk people around

- *This may make things worse because there is a risk they might fall and hurt themselves*
- *It is also possible that as the heartbeat increases with exercise, the drugs will be absorbed into the bloodstream more quickly*

Don't put people in cold baths to wake them up

- *If you have ever heard of people who woke up when they were put in a bath, it was because they were lucky and had not taken a lethal dose. It was not because they were put in the bath.*
- *Putting people in the bath is dangerous because it takes time to run the bath - and they could die while it is filling. Even if they are alive when they are put in, they could easily drown or die of hypothermia.*

Don't hurt, hit or burn people to bring them around

- *You do need to know if someone is sleeping or unconscious. You can tell this by rubbing your knuckles on the middle of his/her chest. If this doesn't wake them, they are unconscious and you need to call an ambulance and start first aid.*
- *Anything more drastic could cause them serious injury!*

Slide 27 (cont.)

Don't inject people with salt water

The idea of injecting people with salt water might have come from people seeing friends in hospital being given a saline (salt) "drip" and thinking this was part of the cure. In fact, the drip is put in to keep a vein "open" so medical workers can inject medication.

Injecting salt water is dangerous because it wastes valuable time and if the salt water is given in a used syringe, it could give him/her HIV or hepatitis!

Slide 28

TIPS FOR PREVENTING OVERDOSE

- Have an OD plan with the people you get high with
- Be careful if you switch dealers
- Ask around: drug strength will vary
- Prepare your own doses/drugs so you know how strong you've made them and exactly what's in them
- Avoid mixing heroin with other drugs
- Avoid shooting alone

Teaching instructions: Use the bullets on this slide to present directly.

SUMMARY

- Risk reduction provides an alternative approach & framework to deal with IDU problems
- Risk reduction principles have been adopted in a number of countries. They have shown to be:
 - pragmatic
 - humane
 - effective
 - holistic
- Risk reduction: a public health approach assisting in the control of HIV infection among IDUs

Teaching instructions: Review the key points of this unit.

👤 Say: *Risk reduction is supported with current scientific evidence and it has demonstrated remarkable achievements. An increasing number of countries are adopting risk-reduction principles because they have shown to be pragmatic, humane, effective and holistic.*

Teaching instructions: Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.

FHI Addictions Counseling Training Manual - Glossary of Terms

TERM	DICTIONARY DEFINITION	ADDICTIONS COUNSELING DEFINITION
abstract thinking	thinking that is not based on a particular instance; theoretical	the ability to think about something from a range of different perspectives
addiction		the overpowering physical or emotional urge to continue alcohol/drug use in spite of an awareness of adverse consequences; there is an increase in tolerance for the drug and withdrawal symptoms sometimes occur if the drug is discontinued; the drug becomes the central focus of life
addiction counseling		professional and ethical application of basic tasks and responsibilities which include clinical evaluation; treatment planning; referral; service coordination; client, family, and community education; client, family, and group counseling; and documentation
affirmation	the act of stating something as a fact; asserting strongly	agreeing with what a client is saying in a supportive way
ambivalence	the state of having mixed feelings or contradictory ideas about something or someone	
arguing	exchanging or expressive diverging or opposite views, typically in a heated or angry way	
attending		listening to verbal content, observing non-verbal cues, and providing feedback that assures you are listening
autonomy	freedom from external control; independence	respecting a client's ability to think, act and make decisions for him/herself
behavior modification	the application of conditioning techniques (rewards or punishments) to reduce or eliminate problematic behavior, or to teach people new responses	

FHI Addictions Counseling Training Manual - Glossary of Terms (cont.)

TERM	DICTIONARY DEFINITION	ADDICTIONS COUNSELING DEFINITION
behavioral counseling	counseling that is based on the premise that primary learning comes from experience	an approach that views counseling and therapy in learning terms and focuses on altering specific behaviors
big deep moments		moments in a conversation that have significant impact on a person's thinking and commitment for change
burnout	physical or mental collapse caused by overwork or mental stress	depletion of motivation, interest, energy, resilience and often effectiveness of counselors caused by overwork or mental stress
case conferencing		a structured meeting between professionals to discuss relevant clinical aspects of a client
cliché	a phrase or expression that is overused and betrays a lack of original thought	
client		individuals, significant others, or community agents who present for alcohol and drug use education, prevention, intervention, treatment, and consultation service
client-centered	conducted in an interactive manner responsive to individual client needs	an approach to counseling that allows clients to retain ownership of their issues and building on their abilities to change behavior
closed question	question with more than one possible answer from which one or more answers must be selected	
cognitive counseling	counseling that is based on the belief that our thoughts are directly connected to how we feel	an approach to counseling which focuses on improving clients' ability to test the accuracy and reality of their perceptions
collusion	secret or illegal cooperation or conspiracy	clinical collusion: conspiring with another individual against a client's interest; remaining silent/not intervening when a client says or does something that (the counselor) knows is morally/legally wrong
competency		the requisite knowledge, skills, and attitudes to perform tasks and responsibilities essential to addiction counseling
confidential	intended to be kept secret	intended to be kept secret for the protection and safety of the client

FHI Addictions Counseling Training Manual - Glossary of Terms (cont.)

TERM	DICTIONARY DEFINITION	ADDICTIONS COUNSELING DEFINITION
confronting	compelling (someone) to face or consider something	expanding (or challenging) a client's awareness via reflections and questions focused on actual and potential inconsistent and illogical ways of thinking and communicating
continuum of care		the full array of alcohol and drug use services responsive to the unique needs of clients throughout the course of treatment and recovery
corrective feedback	information about reactions to a person's performance/ behavior intended to modify or improve the behavior	
counseling	provision of advice, especially formally	an interactive exchange process between counselor and clients to help clients confidentially explore their problems and enhance their capacity to solve their own problems
counselor	a person trained to give guidance on personal, social or psychological problems	counselors are similar to therapists in that they use a variety of techniques to help clients achieve stronger mental health. (one of the most commonly understood methods involves a one-on-one exploration of a client's inner beliefs and background (psychotherapy) or a similar exploration in a group setting (group therapy).)
craving	a powerful desire for something	
denial	the action of declaring something to be untrue	failure to accept an unacceptable truth or emotion or to admit it into consciousness; used as a defense mechanism
directive	involving the management or guidance of something	
disagreeing	having or expressing a different opinion	
discrimination	the unjust or prejudicial treatment of different categories of people or things, usually based on race, sex, gender...etc	
double-sided reflection		reflecting both the current, resistant statement, and a previous, contradictory statement that the client has made

FHI Addictions Counseling Training Manual - Glossary of Terms (cont.)

TERM	DICTIONARY DEFINITION	ADDICTIONS COUNSELING DEFINITION
empathy	the ability to understand and share the feelings of another	
exploration	thorough analysis of a subject or theme	
extrinsic	not part of the essential nature of someone or something; coming or operating from outside	something that comes from the outside; an outside feeling or point of view
goal	the object of a person's ambition or effort; an aim or desired result	
goal-centered	based on the short-, intermediate- and/or long-term goals of an individual or group	working toward achieving specific implicit or explicit objectives of counseling
harm	physical injury (especially that which is deliberately inflicted)	any event or stimulus that causes a negative outcome
harmful use		patterns of use of alcohol or other drugs for non-medical reasons that result in health consequences and some degree of impairment in social, psychological, and occupational functioning for the user
interpreting	understanding an action, mood or way of behaving as having a particular meaning or significance	
intervention	action taken to improve a situation	
intoxication	of alcohol or a drug, the state of losing one's control over one's faculties/ behaviors	
jargon	special words or expressions that are used by a particular profession or group and are difficult for others to understand	
judging	forming an opinion or conclusion about something	forming an opinion about something and projecting it on to other people

FHI Addictions Counseling Training Manual - Glossary of Terms (cont.)

TERM	DICTIONARY DEFINITION	ADDICTIONS COUNSELING DEFINITION
lapse	a temporary failure of concentration, memory or judgement	the reuse of drugs after a period of stopping
moaralizing	commenting on issues of right and wrong, typically with an unfounded air of superiority	
motivational interviewing	a client-centered, semi-directive method of engaging intrinsic motivation to change behavior by developing discrepancy and exploring and resolving ambivalence within the client	
nonjudgmental	avoidal moral arguments	
open-ended question	question whose answers have no determined limit or boundary	
ordering	commanding or giving instruction authoritatively	
over interpreting		placing too much emphasis on a specific client response (verbal or nonverbal)
paraphrasing	expressing the meaning of something someone has written/said using different words, especially to achieve greater clarity	
personal resilience	ability to withstand or recover from difficult situations on one's own	
prevention		the theory and means for delaying or denying uptake of drug use in specific populations. prevention objectives are to protect individuals prior to signs or symptoms of substance use problems; to identify persons in the early stages of substance abuse and intervene; and to end compulsive use of psychoactive substances through treatment
principle	a fundamental source or basis of something	

FHI Addictions Counseling Training Manual - Glossary of Terms (cont.)

TERM	DICTIONARY DEFINITION	ADDICTIONS COUNSELING DEFINITION
probing		asking for more information and/or clarification about a point that you think is important
procedure	an established or official way of doing something	
psychoactive substance		a pharmacological agent that can change mood, behavior, and cognition process
rapprochement	a close and harmonious relationship in which the people or groups concerned understand each others feelings or ideas and communicate well	
reflective listening		to listen carefully to what the client has said and repeat back what was said in a directive way
reframing	framing or expressing words, concepts or plans differently	
relapse	to suffer deterioration after a period of improvement	the return to the pattern of substance abuse as well as the process during which indicators appear prior to the client's resumption of substance use
reliability	the degree to which something is consistently good in quality or performance	
resistance	the refusal to accept or comply with something	any feeling thought and communications on part of the clients that prevent them from participating effectively in counseling.
resourcefulness	having the ability to find quick and clever ways to overcome difficulties	
respect	a feeling of deep admiration for someone or something elicited by their qualities, abilities or achievements	
risk	a situation involving exposure to danger	
rolling with resistance		meeting resistance to change from a client by moving in the direction he/she is headed with a response that is intended to diffuse the resistance

FHI Addictions Counseling Training Manual - Glossary of Terms (cont.)

TERM	DICTIONARY DEFINITION	ADDICTIONS COUNSELING DEFINITION
self-efficacy		belief in a client's own ability to undertake a task(s) and/or fulfill goals
self-responsibility	(responsibility for one's self) - the state or fact of having the duty to deal with one's self	
significant others		sexual partner, family member, or others on whom an individual is dependent for meeting all or part of his or her needs
simple reflection		to repeat or rephrase what the client has said
skill	the ability to do something well; expertise	
sobriety		the quality or condition of abstinence from psychoactive substance abuse
stage of change theory	a theory that espouses that behavior change does not happen in one step, rather, people tend to progress through different stages on their way to successful change; each progresses through the stages at his/her own rate	
substance use		consumption of low and/or infrequent doses of alcohol and other drugs, sometimes called "experimental," "casual," or "social" use, such that damaging consequences may be rare or minor
summarizing	giving a brief statement of the main points of (something)	
supervision	observation and direction execution of a task, project or activity	the administrative, clinical, and evaluative process of monitoring, assessing, and enhancing counselor performance
sympathizing	agreeing with a sentiment or opinion	
sympathy	understanding between people; a common feeling because you have experienced the same or similar event.	

FHI Addictions Counseling Training Manual - Glossary of Terms (cont.)

TERM	DICTIONARY DEFINITION	ADDICTIONS COUNSELING DEFINITION
technique	a way of carrying out a particular task	
therapeutic alliance		the relationship between a mental health professional and a client it is the means by which the professional hopes to engage with, and effect change in, a client
threatening	causing someone to be vulnerable or at risk	
voluntary	done, given or acting of one's own free will	

